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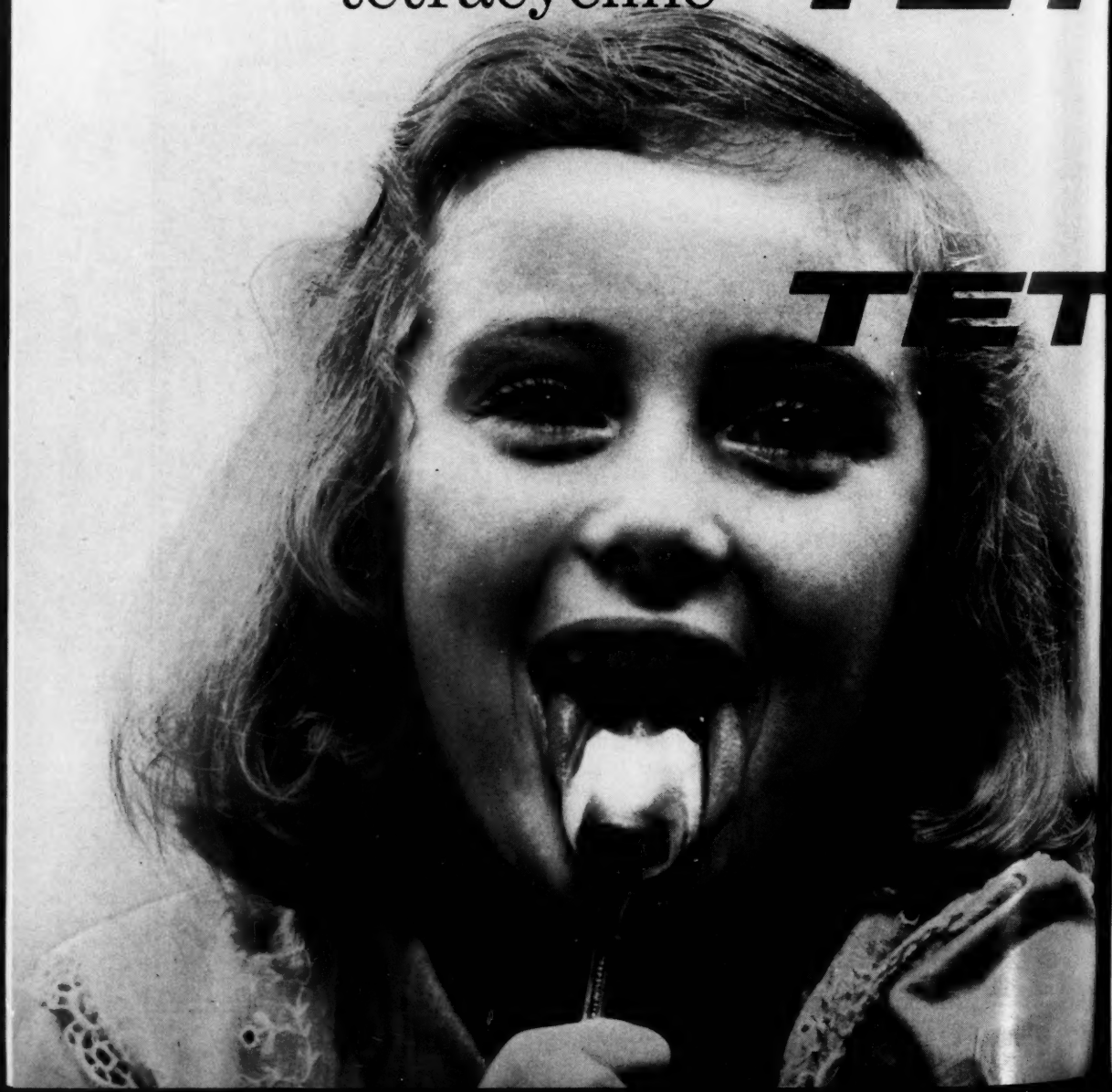

The RHODE ISLAND MEDICAL JOURNAL

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RHEUMATOID ARTHRITIS

Fifteen Years' Experience With Chrysotherapy

JOSÉ M. RAMOS, M.D.

The Author. *José M. Ramos, M.D., of Newport, Rhode Island. Senior Physician and Director of Arthritis Clinic, Newport Hospital.*

A. History of Chrysotherapy

THE USE of gold as a therapeutic agent for rheumatoid arthritis is not new. Lande, in Germany, was the first reported to have used this agent for this disease as far back as 1929, but the greatest impetus to its use was given by Jacques Forestier at Aix-les-Bains, France, in 1929.

His use of this form of therapy was based on the knowledge that gold salts could inhibit growth of tubercule bacilli in vitro. This fact had been reported in 1890 by Koch. Later, other workers reported that gold preparations containing a sulfhydryl (SH) group possessed antibacterial properties, and much was done in the study of gold preparations in treating skin disorders which were considered to be related to tuberculosis such as lupus erythematosis, eczema and psoriasis.

Because of some clinical similarities between rheumatoid arthritis and tuberculosis, it seemed reasonable to Forestier to assume that gold salts might help the rheumatoid patients. This reasoning was also based on the knowledge that gold had an affinity for serous membranes such as the pleura and the synovial membranes. As Copeman and his workers had realized, gold was present in the synovial membranes in much higher concentrations than in the muscle, and that the gold content of the synovial membranes of the arthritic joints was much higher than in the synovial membranes of normal joints.

During the past ten years much has been learned concerning the gold compounds, their pharmacology and metabolism and this has made for a more intelligent use of gold in its application to rheumatoid activity.

B. Mode of Action

The way in which gold compounds act in the human organism when used for treatment of rheumatoid activity is still a matter of conjecture. Various tissue biopsies of patients who had received radioactive gold as gold sodium thiosulfate showed that there was a much higher concentration in the synovial membranes and fluid than in muscle, fascia or skin. It is varied mainly in the plasma components of the blood, most probably bound to the plasma proteins.

The failure of gold to protect guinea pigs against large doses of histamine, and the absence of an effect of Arthus phenomenon did not suggest that it had an antiallergic action.

Since particles of gold had been found in the reticulo-endothelial cells, it was thought that possibly gold stimulated the reticulo-endothelial system. There has been no evidence to support this theory.

Another theory suggested that gold compounds might exert their therapeutic effect by changing tissue enzyme reaction. In vitro studies on rat tissues failed to confirm this hypothesis.

Lately some workers have had the opinion that gold compounds may, perhaps, stimulate the adrenal cortex, and thereby produce their therapeutic effect. Much work was done to disprove this theory by Bruce and Mackay at the North Royal Infirmary, in Inverness, Scotland. They investigated to see what changes, if any, took place in the urinary excretion of neutral 17-ketosteroids in the cases that were selected for gold therapy, and found that chrysotherapy did not produce any change in the 17-ketosteroid excretion level in the cases that benefited from this therapy.

Davison, Koets, Kuzell and others also found the ketosteroid excretion to be within the normal range in these cases and suggested that cases of rheumatoid arthritis deriving benefit from chrysotherapy could not attribute their improvement to any action on the adrenal cortex.

C. Administration of Gold

There are various preparations of gold repre-

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senting different chemical and physical types of gold compounds. The gold preparations most frequently used are: 1) Sanochrysine, a gold sodium thiosulfate solution, soluble in water and containing 37% gold. 2) Myochrysine, a gold sodium thiomalate, also soluble in water, and containing 50% gold. 3) Solganol-B Oleosum, a gold thioglucose in oil suspension and also containing 50% gold.

The latter form, or Solganol-B Oleosum, was used almost exclusively throughout these series of cases during at least twelve of the fifteen years of therapy of rheumatoid cases. During the first three years Gold Sodium Thiosulfate (Abbott) was used in intravenous doses of 10 and 25 mgm. Retrospectively one appreciates the latter method as having been really an heroic mode of therapy given its extremely rapid absorption and its high blood concentration a few hours after injection. The reactions to gold were frequent and sometimes severe depending upon the individual susceptibility.

An oil suspension of a soluble gold salt such as gold thioglucose given intramuscularly is slowly absorbed, and produces lower plasma gold concentrations with less frequency of reactions to gold. This oil suspension was used by us not because of its superiority to either Sanochrysine or Myochrysine, but merely due to the fact that it was a product that we had been accustomed to handling and were familiar with its various reactions and the various individual idiosyncrasies that were associated with it.

The all-important factor in the use of Chrysotherapy reduces itself to the routine in which the gold compound is administered, or the schedule that is applied in cases of rheumatoid activity.

Until 1945, the routine that was customarily used and applied in this office, was the administration of gold in graded doses beginning with 10 mgm. weekly for four weeks and then 25 mgm. weekly for four weeks with a continuance of 50 mgm. weekly until a total dose of 1 to 2 gms. of the drug had been administered. This routine was modified by the reaction of the individual to gold or interrupted entirely according to the severity of the toxic symptoms. A rest period of two months was then given and another course, or as many of four courses, were given until a satisfactory outcome was reached and no further relapses occurred. This was recognized as the method "ad modum Steinbrocker."

The method used by us since 1945 was a slight modification of this schedule, taking into consideration the fact that among patients receiving higher doses of gold compounds there was a tendency toward greater improvement but also towards increased toxicity. A fairly good compromise was reached with a schedule which, we think, gave good end results and at the same time circumvented the highly toxic reactions of the drug.

The average total dose of gold was 1.250 grams and given in this manner: for the first six weeks the patient received 25 mgms. of gold thioglucose every four days. It was during this period that the reactions to gold were the most frequent. At the end of this period 25 mgms. were given once weekly for six weeks; then 25 mgms. were given every two weeks for six doses. At this time the same doses were continued once every three weeks for six doses, and then once a month up to a period of two years from the beginning of therapy.

Up to the present time, after a ten-year period, we have seen but three relapses out of our total of thirty-six cases treated under this program. All three of these cases had had their therapy interrupted for a period of one year or more due to various domestic reasons.

One can readily appreciate the necessity of having the patient adhere rigidly to the program outlined to him beforehand.

The schedule last outlined, is developed more or less according to the precepts of Hartung, and in our hands has proven highly satisfactory thus far.

D. Selection of Cases and Diagnosis

The selection of cases suitable for gold therapy is an extremely important consideration and one about which there should be little or no debate. It postulates one's familiarity with the metabolism and pharmacology of gold and the nature of the disease to be treated.

First of all, one should be convinced clinically that the disease is that of rheumatoid activity, and secondly, one should explain to the patient that gold contributes only insofar as it arrests the disease but does not repair the damage done to cartilage and bones, nor does it restore deformed and ankylosed joints. It is also important, insofar as the patient and his financial economy are concerned, that one does not subject a patient *suspected* of rheumatoid activity to a course of three years of therapy uselessly, with all its attendant therapeutic complications.

The ideal objective in the treatment of patients with rheumatoid arthritis is to prevent crippling deformities and incapacitations and to have him restored as much as is possible, to complete rehabilitation. To wait until the gold treatment be used as a last resort is only fostering poor and unimpressive results, since joint damage has already taken place and the destructive changes already present cannot be remedied.

Proper use of gold salts in the early stages of rheumatoid arthritis with active synovitis produces gratifying results. It has been found by many workers that in the symptom-free group treated with gold most were treated within one year of onset of the disease.

It has been the opinion among many rheumatologists, however, that one should observe early cases during the first three months, not instituting gold therapy at the onset, but evaluating the progress of the disease at monthly intervals and resorting to physical therapy, intra-articular injections of Hydrocortisone acetate and active exercise. If gratifying results are obtained, then gold therapy is held in abeyance until such time as the disease seems to be advancing in spite of these measures last mentioned.

In choosing the specific cases for gold therapy certain criteria have been helpful:

1) X-ray findings are generally disappointing and one should not rely too much on this examination. However, punched-out areas of bone destruction in the subchondrial areas are significant especially if it is co-ordinated with the patient's history and clinical findings. Usually one finds these areas of decalcification or bone destruction in the metatarso-phalyngeal joints of the feet as the first manifestations. These appear under the big toe first since this is the point of greatest trauma.

2) The sedimentation rate is elevated in about 90% of the cases. However, in the remaining 10% where there is no elevation of the sedimentation rate one must rely upon one's clinical acumen and the other laboratory tests to give one the clue.

3) 'Protein Metabolism—many workers such as Wallis, Salt and Olhagen have found that in most cases of rheumatoid activity there is a tendency towards a reversal of the A-G ratio, a drop in the total serum protein level, an increase in the plasma fibrinogen, and a positive thymol turbidity test.

4) Agglutination of Sensitized Sheep Cells—apparently it is now well established that the serum of (more than half) of the rheumatoid patients will increase the specific agglutination of cellular antigens. In the work done by Ziff, Brown, Badin and McEwen, 92% of the patients with adult rheumatoid arthritis gave a positive test.

5) Lately it has been suggested that, in addition to employing the usual erythrocyte sedimentation rate, as a measure of rheumatoid activity, one resort to a method which has been found to be more reliable and more stable: The *serum polysaccharide-protein ratio.* The polysaccharide-protein ratio is obtained by dividing the polysaccharide concentration by the serum protein and multiplying the result by 100. An elevated serum polysaccharide-protein ratio occurs, apparently, in active rheumatoid arthritis and other collagen diseases. It can be utilized as a measure of the degree of clinical activity.

An increased clinical activity of the disease is accompanied by a proportionate rise in the polysaccharide-protein ratio, while a remission is attended by a fall in the ratio. This ratio remains constant in the normal individual and undergoes only slight change in minor infections or trauma. Although inflammatory states, neoplastic diseases and severe trauma seem to affect this ratio, they are *seldom* of a severity sufficient to bring about an alteration in it.

E. Effect of Gold in Applicable Cases

In cases of rheumatoid activity where conservative therapy has not produced gratifying results within the first three months, and gold treatment is instituted at this time, one finds in the majority of cases an almost immediate response.

Following are the statistics on the thirty-six patients treated by us during the past fifteen years. They have been graded according to time in which loss of pain and oedema, return of mobility and complete rehabilitation took place after therapy.

Months	1	2	3	4	6	8	12	24
Loss of Pain	36%	48%		.02%	.02%		.02%	
Loss of Oedema	41%	50%		11%				
Return of Complete Mobility	25%	33%	.02%	30%	.8%			
Complete Rehabilitation	22%	25%		.8%	11%	.02%	.05%	13%

One patient had loss of pain after the first injection. This was a case of acute rheumatoid activity of three months' duration. Another patient had loss of pain only after one entire year of treatment. This person was an extremely hyperexcitable individual who suffered more muscle spasms than actual articular pain.

Before the twelfth week of gold therapy the majority of the patients were able to state that no longer were they susceptible to barometric pressure changes which had heretofore always heralded an onslaught of polyarticular pain and synovial sensitivity. This refractoriness to barometric pressure changes has been used as a criterion, in this office, for future steady improvement.

Practically all patients, once having gone beyond this hurdle, complain very little even after performing their usual routine, daily occupations.

We must mention that the entire period of gold administration was constantly accompanied by physical therapy and active exercises. This latter consideration is all important in the objective of complete rehabilitation of the patient.

F. Gold vs. Other Drugs

1. *Cortisone and ACTH.* Though Cortisone and ACTH have been effective in their anti-rheumatic activity, they have not been without their serious drawbacks and consequences. In addition to the

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fact that rheumatoid cases would have to be placed under perpetual Cortisone therapy in order to avoid relapses, in which case the cost is staggering to the patient, the side reactions of these hormones under long-term therapy is well known.

The results produced upon withdrawal of the steroids have been studied by such workers as Ball of the Rheumatism Research Centre at the University of Manchester, England, and Slocum of the Mayo Clinic. They have shown that there exists a panmesenchymal and panangiitic reaction that carries all the risks of polyarteritis nodosa or of acute lupus erythematosis. The effects of these hormones are temporary and suppressive but not curative.

The intra-articular injections of a steroid such as Hydrocortisone Acetate in repeated injections offer a fairly consistent, long-lasting palliation but only time will tell whether the alleviating effect of this drug will result in long range benefits to the patient.

2. *Copper.* The use of copper salts such as Cupralene was introduced in 1949 by the Father of gold therapy, Jacques Forestier, of Aix-les-Baines, France. He advocated its use during the subacute stage of rheumatoid activity and claimed that they gave better results than gold salts in these cases. Work done in the United States with this therapy did not bear out his contentions, however.

3. *Butazolidin or Phenylbutazone.* In rheumatoid spondylitis Butazolidin is the drug of choice and the results have been found to be superior to either Cortisone, ACTH or X-ray therapy. However, the prolonged administration of the drug is accompanied by a great deal of danger toward agranulocytosis and must be given with the utmost care.

Like Cortisone and ACTH, Butazolidin does not arrest the disease but gives only temporary palliation.

G. *Gold Toxicity.* Toxicity from gold administration may manifest itself at any time after the initial injection. In our experience most of the manifestations of gold toxicity showed themselves within the first six weeks of therapy, the most frequent being skin rashes on the nature of an eczematoid dermatitis. Frequently one encountered patients who complained of a generalized pruritis without any evidences of a skin irritation.

Other manifestations of toxicity were: nausea, abdominal cramps and occasionally diarrhea, headache, sub-sternal oppression, vertigo and a metallic taste in the mouth. In one case there was a flare-up of giant hives or angio-neurotic oedema.

None of these evidences of toxicity was considered as a contra-indication to further gold therapy. After a resting period of three to four weeks, when all symptoms had disappeared, gold injections were resumed.

At no time, in our fifteen years of experience with Chrysotherapy, did we encounter a case of exfoliative dermatitis or agranulocytopenia due to bone marrow inhibition. Extreme caution upon the first manifestation of skin reactions perhaps helped to avoid the former danger, and the use of purified liver extract, 10 mcgr. per c.c., given with each gold injection perhaps helped to avoid the latter.

As it has been mentioned by Freyberg, there are many indications that gold toxicity in human beings is an allergic type of reaction. The fact that there is an occurrence of dermatitis of an eczematoid form after only one, two or three injections; the frequent occurrence of esinophylia preceding and during the toxicity; that some times there is a development of toxicity following a single, small injection of gold given after an interval of many weeks following completion of a course of gold that was well tolerated; all these point to an allergic concept.

It has been significant in our experience that those patients who were found to have an allergic substratum, either in the form of an allergic rhinitis, frank bronchial asthma, gastro-intestinal allergy or allergic dermatitis, were precisely those who manifested a gold toxicity. In all these cases the administration of Cortisone, either parenterally or orally, for three to four days subsequent to their injection of gold warded off all signs of toxicity, that had manifested themselves on previous injections.

Experience has shown that many conditions formerly thought to be contra-indications to gold actually are not. Allergic diseases no longer prevent the use of gold therapy since the concomitant administration of Cortisone can mitigate the toxic reactions.

Pregnancy is not necessarily a contra-indication, since many pregnant patients have tolerated the therapy well and with no untoward reactions to the child. Rheumatoid patients, however, are benefited by pregnancy and gold therapy is seldom desired throughout this period.

Serious kidney or liver disease with functional impairment of these organs, blood dyscrasias, hemophilia and severe anemia are considered to be definite contra-indications to gold therapy.

When gold therapy is beneficial, in the well-done cases, it is most gratifying to note the signs of inflammation decreasing, the gradual and progressive lessening of pain and the improvement in articular functioning. Thus far, gold is the only drug at our command that produces an arrest of the rheumatoid activity when employed in a well-planned program of treatment. After twenty-five years of use it remains as our only effective agent, and the availability of Cortisone and ACTH have helped us to reduce further the risks of toxic reactions.

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THE MEDICAL ADVISORY COMMITTEE AND THE DISABILITY FREEZE

CHARLES L. FARRELL, M.D.

The Author. *Charles L. Farrell, M.D., of Pawtucket, Rhode Island. Member, Medical Advisory Committee to the Social Security Administration; President, Conference of Presidents and Other Officers of State Medical Associations; President-elect, Rhode Island Medical Society.*

LAST FEBRUARY, a Medical Advisory Committee was appointed to advise the Social Security Administration in connection with medical policies involved in the new "disability freeze" provision. Medical practitioners may be interested in learning about the composition and activities of the Committee and of the operations of the "freeze" provision since many of their patients undoubtedly have rights under this provision.

The disability freeze provision permits a qualified individual to maintain his old-age and survivors insurance rights during extended periods when he is totally disabled by reason of a medically determinable physical or mental impairement.[1] For the long run, the determinations of disability will be made mostly by the vocational rehabilitation agency or by another appropriate agency in the applicant's own state, under agreements negotiated between the states and the Secretary of Health, Education, and Welfare. The Bureau of Old-Age and Survivors Insurance is responsible for making determinations in cases not covered by State agreements.

Determinations of disability are made with a "team" approach—i.e., by a physician and a qualified counselor or lay person skilled in evaluating the effect of impairments on ability to work. In many States the physician member of the "review team" is in private practice and serves as a consultant to the State agency for purposes of making freeze decisions. The role of the attending or examining physician in submitting the medical report is of paramount importance to the program, for it is on the basis of the clinical findings and other medical evidence in the report that a determination of the severity of the impairment is made. By submitting accurate, specific reports, the physician can render assistance to the applicant and at the same time facilitate fair and proper disposition of the claim.

[1]For an individual to become entitled to monthly old-age insurance (i.e., retirement) payments or for his family to become entitled to monthly payments in case of his death, he must meet a minimum work requirement under social security. The amount of his payments is then calculated from his average monthly earnings in work covered by social security. The new law preserves a disabled worker's rights and permits his period of disability to be excluded in determining the amount of his benefit.

The Purposes of the Medical Advisory Committee

In agreeing to serve on the Medical Advisory Committee, the members of the Committee affirmed their understanding that the disability freeze definitely does not include nor contemplate cash payments before age 65, nor any type of State or governmental treatment other than that now existing or available to the States under present laws.

Briefly, the purposes of the Medical Advisory Committee are:

1. To provide technical advice and consultation regarding medical aspects of the administration of the freeze provision.
2. To promote mutual understanding and effective working relationships among the Social Security Administration, cooperating State agencies, and physicians generally.
3. To provide professional guidance in formulating medical guides and standards for evaluating disability.

Composition of the Committee

The membership of the Committee represents a wide variety of skills in medical practice and public and private medical and welfare administration. The Social Security Administration and the State agencies administering the freeze provision would thus have the benefit of diverse professional experience. Among the professional and industrial groups represented on the Committee are general medical practice, internal medicine, physicial medicine, preventive medicine, ophthalmology, surgery, vocational rehabilitation, orthopedics, public health, labor unions, and social welfare agencies.[2] Insofar as possible the major geographical sections of the country are represented, also.

Accomplishment of the Committee

The Committee met with representatives of the Department of Health, Education, and Welfare in Washington in February, March, and May, 1955.

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A report of its recommendations to date has been submitted and recently published.[3] Additional meetings will be held in the future.

One of the problems considered by the Committte relates to the responsibility placed on the applicant by law to furnish proof of his disability. To carry out this provision, the Committee found it reasonable for the Bureau of Old-Age and Survivors Insurance to advise the applicant to secure a *current* medical report from his own physician or from another medical source, hospital, clinic, or agency, based upon an existing medical record or upon a current examination. This report, if it is complete and factual, will ordinarily be sufficient to establish the degree of severity of the applicant's disability. In some cases there will be need for additional medical information, and occasionally, an additional examination. The "review team" may need additional reports of diagnoses and clinical findings from existing records, and will advise the applicant that he must secure these.

Where the initial medical report submitted by an applicant's physician *fails to establish the severity of the impairment, the physician in the administering agency may write directly to the applicant's physician for additional data.* It is believed that this approach will preserve and strengthen the doctor-patient relationship. If the necessary information cannot be provided by the attending physician without a further examination, the *applicant will need to be informed* and *must be responsible* for *any fee charges,* since it is part of the *applicant's own responsibility to prove his disability.* A medical examination at the expense of the Government may be authorized only in the exceptional case where, in the judgment of the review physician, it seems necessary to verify facts to insure that an improper award will not be made.

The Committee also considered operating instructions to be issued to State agencies and the medical criteria for evaluation of specific impairments and combinations of impairments. These proposed guides and standards were reviewed and analyzed by sub-groups of Committee members with specialized training and experience in the particular subject matter under study. The sub-groups made a number of suggestions to clarify the material and bring it into conformity with most recent developments in medical science. The Committee approved the use of the medical guides as an initial basis for operations during the coming months. These criteria establish a test of severity which an applicant's impairment must meet in order for him to qualify for the freeze.

How the Attending or Examining Physician Can Help

The Committee feels that practicing physicians should have a real understanding of the freeze provision since many of their patients will be asking them for medical reports to be submitted to the appropriate agency in their State to establish their disabilities. Ordinarily a person so severely disabled as to qualify for a freeze will be under the medical care of a physician or will have had a medical examination for his condition.

Medical reports are normally submitted directly to the Social Security Administration for transmittal (together with the application and other papers) to the State agency making the disability determination, rather than through the applicant. The report form calls for pertinent history, clinical findings and diagnosis. It is purposely short and simple, intended to be flexible. Use of any other form, or a narrative statement is acceptable, so long as the information contains the necessary facts relating to pertinent history, symptomatology, clinical findings and diagnosis. Because various State and Federal disability provisions established by law operate under legally defined concepts of disability, definitions among programs differ. Reporting physicians are not asked to decide whether the applicant is under a disability. Their responsibility, instead, is to give the agency medical facts and findings sufficient for its physician to reach a conclusion as to diagnosis and the severity of the impairment, and therefore determine whether the applicant meets the definition of disability for this program.

Experience to date with the medical report form has been generally good, but some of the reports received contain insufficient medical findings to permit a reviewing physician to evaluate the extent and degree of the impairment. In such case, it is necessary to ask the reporting physician to describe more precisely his findings. Consideration was given by the Medical Advisory Committee to revising the present form to call for more detailed information. However, it was agreed at the May meeting that the present medical report form could be used until more experience indicated the kind of revision necessary. Comments from practicing physicians are welcome. Their opinions are highly regarded and carefully considered.

SUMMARY

In February, the Commissioner of Social Security appointed a Medical Advisory Committee representative of different specialties, including general practice, and different geographical portions of the

[2]The Committee appointed by the Social Security Administration in the U. S. Department of Health, Education, and Welfare consisted of the following members: See list on page 629.

[3]*Medical Advisory Committee Report and Recommendations on the Administration of the OASI Disability Freeze Provision*—copies for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 10 cents per copy or 100 copies for $7.50.

country to advise him with respect to the medical policies involved in administration of the new disability freeze provision. The Committee has met, considered and approved for the early months of operation, proposed guides and standards fixing the responsibility for obtaining evidence of disability and the type and amount of evidence required to establish disability. Since the applicant has the responsibility of presenting proof of disability, he will need the cooperation of his attending physician. The latter should furnish the administering agency with a current report of medical findings sufficient to permit a decision to be made as to the severity of the impairment and whether the applicant is "disabled" as defined by law.

MEDICAL ADVISORY COMMITTEE ON DISABILITY FREEZE

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RHEUMATOID ARTHRITIS

concluded from page 626

It is true that it is by no means an ideal drug, and improvements in treatment for rheumatoid arthritis may develop in such a trend as to eliminate the need for gold therapy. At that time all those engaged in chrysotherapy will be the first and the happiest to abandon it in favor of superior treatment.

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PHLEBITIS*

JOHN J. BYRNE, M.D.

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At the Reunion Day of St. Joseph's Hospital Staff Association on September 7, 1955, Dr. John J. Byrne was one of the group that gave a symposium on "Peripheral Vascular Disease." His talk on "Thrombophlebitis" was a most interesting one and he backed it up with a large number of excellent statistics. Statistics are valuable, but they do not make especially lively reading, and as the aforesaid statistics have been given elsewhere, we asked him if he would not write us an article giving his views and allowing us to certify the excellence of the statistics. He promised to do this and we are greatly pleased to present at this time his ideas on phlebitis.

THE EDITOR

THERE IS much confusion about the best treatment of phlebitis. The most important reason for this is the lack of knowledge of the basic cause of the disease. Until we can find the essential factor that produces phlebitis, we will be at our wits' end in treating it.

We know there are three general factors capable of initiating thrombosis: damage to vein intima, stasis of the circulation, and increased coagulability of the blood. The intima of the vein may be altered by trauma, infection, chemical agents, and even hypoxia. Processes which may produce circulatory stasis are heart disease, varicose veins, pregnancy, hemiplegia, bed rest, tight abdominal binders, obesity, shock, and diminished respiratory ventilation. Changes in the coagulability of the blood are known to be associated with the postoperative period, blood dyscrasias (polycythemia vera), neoplasm, infection, and dehydration.

Although we do not know the cause of phlebitis, we are certain of the diseases which predispose to it. A recent study of a large series of patients at the Boston City Hospital revealed the following diseases to be associated with phlebitis in this order of frequency: cardiac disease, postoperative state, trauma, infection, varicose veins, pregnancy, hemiplegia, cancer, and a small idiopathic group.[1]

Besides being the most frequent primary disease associated with phlebitis, cardiac disease is an associated factor in most of the other cases. Not only are cardiac patients more predisposed to phlebitis, but they are less able to withstand the embolism which may occur. Approximately 73 per cent of the fatal pulmonary emboli were associated with heart disease.

The hemiplegic cases require special note, since most of the fatal pulmonary emboli were unsuspected. The majority of the hemiplegic cases were either holding their own or improving when they died of the pulmonary embolism. This is mentioned solely to deter a pessimistic attitude toward the hemiplegic. A large percentage of these people will go on living many fruitful years. Whenever a physician treating a hemiplegic patient discovers that the paralyzed leg becomes swollen or exhibits varicose veins or other signs of the phlebitic syndrome, he should actively treat this disease to prevent embolism.

Migratory phlebitis was seen in a few of the cancer patients in this series. We are well aware of the association of this disease with Buerger's disease. Too often, its association with carcinoma is not thought of.

In order to prevent phlebitis various measures must be taken to combat some of the factors mentioned in the second paragraph. The most useful measures are compression bandages on the legs, continuous ambulation, and elevation of the legs of bedridden patients. Continuous ambulation should be emphasized in surgical patients because too often a patient is bedridden before surgery and then is immediately ambulated the day after surgery. Preoperative as well as postoperative ambulation should be the rule.

Despite all prophylactic measures phlebitis, with its attendant pulmonary embolism, will occur. I firmly believe that the best prevention against pulmonary embolism *is the early diagnosis and prompt treatment of phlebitis.* The lower extremities of all patients confined to a hospital should be checked daily by the physician in order to elicit any calf discomfort or any other evidence of phlebitis. Physical examination may elicit any of the following signs: calf tenderness, edema, tenderness along the popliteal or femoral veins, positive Homans sign, distended veins in the involved extremity, arterial spasm, or cyanosis. The presence of superficial phlebitis in any patient, particularly the elderly,

*Presented at the Reunion Day of the St. Joseph's Hospital Staff Association, Providence, Rhode Island, September 7, 1955.

should always arouse a suspicion of an underlying deep phlebitis.

The nursing staff should also be alerted to the possibility of phlebitis and should aid in the detection of this disease. The nurses are more closely associated with the patient than the physician. They see them hourly on the wards and are more apt to be informed of any slight calf discomfort than is the physician. Physicians teaching nurses should emphasize this particular point.

As soon as the diagnosis is made, phlebitis should be treated by whatever measure the physician considers of value. One should never wait for a pulmonary embolism to occur before treatment, since at the Boston City Hospital the first embolus was fatal in over 80 per cent of the cases.

There is much discussion as to whether phlebothrombosis and thrombophlebitis are separate processes. It is often thought that phlebothrombosis with minimal signs has a high rate of pulmonary embolism, and that thrombophlebitis with its more obvious pain, tenderness, and edema is associated with a low rate of pulmonary embolism. This often lulls a physician into a false sense of security when treating so-called thrombophlebitis. At the Boston City Hospital there was such a high rate of embolism with the two processes that both should be treated as actively as possible.

Today, there are two ways of preventing pulmonary embolism in phlebitic patients: the administration of anticoagulants or proximal venous interruption. Anticoagulant therapy consists of prescribing heparin for the first several days until Dicumarol or Danilone are giving satisfactory blood levels. The clotting time for heparin therapy should be approximately thirty minutes, and a prothrombin time of thirty to forty seconds should be maintained with Dicumarol or Danilone.

The usual contra-indications to anticoagulant therapy are failure of such therapy to prevent emboli, recent postoperative cases, cerebral hemorrhage, recent post-partum cases, hepatic or renal disease, bleeding diatheses, subacute bacterial endocarditis, and large ulcerating areas. In addition to these contra-indications there are definite theoretical disadvantages to anticoagulant therapy. In the first place, one cannot get as quick a protection as with surgical division. Several of our patients died within twenty-four hours of admission before proper blood levels could be obtained. Secondly, it is a well-known fact that in spite of adequate prothrombin or clotting time levels, fatal emboli have occurred. Thirdly, one is never sure when to stop anticoagulant therapy. Several of our fatal cases occurred after the anticoagulant therapy had been omitted.

There are definite hemorrhagic complications of anticoagulant therapy. Sloughing areas associated with hematomas are time-consuming and add weeks or months to a patient's hospitalization. Some of the hemorrhages have been fatal.

The mortality rate for a small series of cases treated with anticoagulant therapy at the Boston City Hospital was 29 per cent as compared to a mortality rate with no treatment of 37 per cent in a larger series of cases

In contra-distinction to the above-mentioned high mortality rates, surgical treatment demonstrated a rate of only 2.1 per cent. Although surgery gave by far the best results in preventing emboli, some failures occurred. By analyzing these as well as reviewing the successful experiences, the following scheme of treatment has evolved:

Surgical division of the superficial femoral veins should be done when the phlebitis is confined to the calf veins. Division, rather than ligation, is emphasized since we have had cases which have recanalized and thrown off fatal emboli after ligation. Following the femoral division compression bandages should be applied to the legs, and the patient should be ambulated as soon as possible. Following bilateral superficial femoral division, if signs of phlebitis occur proximal to the division, vena cava division or anticoagulant therapy is needed. The choice will depend upon the condition of the patient.

A division of the common femoral vein should be performed if there is evidence that phlebitis is present in the thigh veins. Signs of this would be tenderness along the femoral veins, edema in the thigh, obvious disease in the deep femoral system at the time of surgery, or in phlebitis accompanying fractured femurs when it can be assumed that there is disease in the thigh veins. These cases should have Ace bandages and early ambulation following surgery. The possibility of the phlebitis spreading proximally should be carefully noted so that further therapy can be instituted.

During division of either the superficial or common femoral veins, if the blood clot cannot be easily removed to give a strong retrograde flow of blood, either a vena cava division or anticoagulant therapy is indicated. The chief consideration here is the physical condition of the patient, since a vena cava ligation is a serious operation and should not be contemplated on patients who are poor risks.

When phlebitis is obviously in the iliac or other pelvic veins, cava division or anticoagulation is necessary. There is one difference, however, in that bilateral ovarian vein division should accompany the vena cava ligation in women.

What is the best treatment after a pulmonary embolism has occurred? Essentially, it will depend upon the site of the phlebitis. However, the size of the embolus may be a deciding point, particularly if vena cava division is under consideration. With serious clinical or X-ray signs of pulmonary em-

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THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

Part III

SEEBERT J. GOLDOWSKY, M.D.

(*concluded from October,* 1955, *volume* XXXVIII, *number* 10, *page* 593)

The Author. *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

WITH THE CLOSING of Brown University Medical School the first two centuries had almost come to a close. The beginning of the modern era began some forty years later with the opening of Rhode Island Hospital. We shall retrace our steps with a quick survey of the growth and development of hospital practice in the state, culminating in that important event. The earliest hospitals were of three general categories: military; marine, for the care of sick merchant seamen; and quarantine, for isolating patients with such diseases as smallpox and yellow fever. There appears to have been an overlapping of functions in the latter two types. The buildings provided were usually of modest proportions and were frequently merely private homes requisitioned for hospital purposes. Newport established a smallpox hospital on Coaster's Harbor Island in 1716, while Bristol procured a house for the same purpose as early as 1732. In 1792 an older quarantine building in Newport was rejuvenated as a smallpox hospital.

During 1777 a military general hospital was established at Tiverton for the handling of casualties expected in the local operation against the British, known in history as the Battle of Rhode Island. In 1789 a United States Marine Hospital was established at Newport, but this had a brief career, having been discontinued before 1802, according to official government reports. There is some evidence, however, that this facility operated much longer, inasmuch as Doctor David King of Newport wrote in 1859 that Doctor Edmund Thomas Waring served for some thirty years as "Physician of the United States Marine Hospital . . . thus occupying a post which the extensive commerce of Newport rendered both lucrative and important."

Early Providence Hospitals

Between 1752 and 1776 the Town of Providence provided three smallpox hospitals, the first two being in North Providence and at Tockwotton. The third, built in 1776, was in the general vicinity of the present city yards on Henderson Street. In 1798 at the height of the yellow fever epidemic of that year, the town built a new hospital on the west side of the river near the site of the one last mentioned, for the reception of patients with that disease. A bill for labor and materials still extant among the old town papers designates this building as the "new hospital," and maps subsequent to this period for the next two or three decades designated these buildings as the "old hospital" and the "new hospital." Just when the latter acquired the designation of the "Marine Hospital" is not clear. At any rate it is important to us so identified as it still stands and provides a link with the past. It stood originally on the present location of the old Rhode Island Hospital (soon to be torn down). Upon the building of that structure it was moved to its present site near the Lockwood Street entrance and still serves as the employment office. The porch was not part of the original edifice. We have noted earlier that Doctor Levi Wheaton served it as physician for many years and probably used the clinical material for teaching purposes. In 1900 on the occasion of the opening of a new pavilion at the Rhode Island Hospital, Doctor J. W. C. Ely, the only surviving member of the original staff, pro-

Fig. 7. The "New Hospital," also referred to as the Marine Hospital, before removal to its present site on the grounds of the Rhode Island Hospital, where it is presently used as the employment office. *(Reproduced from Fields "State of Rhode Island and Providence Plantations," 1902)*

vided the following reminiscence: "On it stood a long, low two story building, used by the city for contagious diseases, especially ship fever and smallpox. During the fifteen and one half years of service as city physician, I gained most of what clinical knowledge I have of small-pox and typhus fever in that building." It was last used for patients during the Civil War. In the summer of 1862 Governor Sprague requisitioned it to provide shelter and food for invalid and wounded soldiers passing through Providence on their way home to other states. It was closed after one year, having received during its period of operation 750 casualties, "embracing many wasting away under disease engendered by the exposure of the field, or suffering severely from wounds."

We have noted earlier that the city acquired property at Field's Point in 1824 for the establishment of a smallpox hospital. A sentinel was kept on the Point to flag down ships for quarantine purposes, as provided in town quarantine regulations. This facility was maintained on a stand-by basis, although rarely used, until the Providence City Hospital for contagious diseases, later the Charles V. Chapin Hospital, was opened in 1909. A photograph of the old building published in 1902 revealed it to be hardly more than a hut.

Fig. 8. The Smallpox Hospital at Field's Point. ***(Reproduced from Fields "State of Rhode Island and Providence Plantations," 1902)***

In 1829, one year after the building of the Arcade and the opening of the ill-fated Blackstone Canal, the benefactors of the community incorporated the Providence Dispensary to provide medical care and medicines to the indigent residents of the city on a home care basis. The dispensary had no beds. It disappeared from the scene around the turn of the century.

Mrs. Anne Royal of the City of Washington, writing in her "Sketches of History, Life and Manners in the United States," made the following observations about Providence in 1826: "Providence is a very romantic town, lying partly on two hills and partly on a narrow plain, about wide enough for two streets. . . . It contains 14 houses for public worship, a college, a jail, a theater, a market-house, 8 banks, an alms-house, part of which is a hospital, and 12,800 inhabitants [a fairly accurate estimate]. The churches are very splendid, and the jail is tolerable, but the poor-house does not deserve the name, and the hospital is a wretched abode, disgraceful to the town. . . . The poor-house is in an old building in the most unwholesome part of the town. There were about twenty paupers in it, the dirtiest set of beings I ever saw. I found five maniacs in the hospital, lying on straw upon the floor, which looked as though it had not been swept or washed for years. The citizens, however, are engaged in measures to render these establishments more comfortable."

Among these measures, whether or not she was aware of it, was the bequest by Ebenezer Knight Dexter upon his death in 1824 of $60,000 (a sizable sum for that period) for the benefit of the poor people of the town. Plans were undertaken in 1826 to build an asylum in accordance with the provisions of the will. Although the edifice was not completed until 1830, occupancy began in 1828 with 64 paupers, increasing gradually to a census of 125 in 1895. For some twenty years until the opening of Butler Hospital it also provided shelter for the insane, one quarter of its inmates at times belonging to that category. According to Doctor George V. Hersey it was the only maternity home in Rhode Island before the opening of the Providence Lying-In Hospital in 1884, "and many children have been born beneath its sheltering roof." Pending some final litigation its days now appear to be numbered.

The first major medical institution in the city resulted from a bequest of $30,000 in 1841 by Nicholas Brown for the erection and endowment of a retreat for the insane. This was followed by other gifts, the largest amounting to $40,000 by Cyrus Butler after whom the institution was to be named. Chartered in 1844 it received its first patients in 1847. It began operations under the direction of Doctor Isaac Ray, the first of a line of distinguished superintendents. After a long career, during which it had acquired an international reputation, it has but recently closed its doors.

Another military medical establishment warrants our attention. In 1862 under the supervision of the War Department a general hospital was activated at Portsmouth Grove, a locality in the town of Portsmouth, Rhode Island. This obviously was a major undertaking. Its first allotment of patients, 1724 in number, arrived on July 6th of that year. The installation comprised 58 buildings, including 28 for wards and 30 for mess hall, kitchens, laundry, stores, dispensary, commissary, enlisted and officers' quarters, blacksmith and carpenter shops and other service facilities. It provided a chapel, auditorium and library. Through August 1, 1863,

continued on next page

the first year of its operation, it received 6,866 patients, of whom 101 were to be buried in the attached cemetery. At some point it acquired the name Lovell General Hospital, a somewhat nostalgic one to a later generation of Rhode Island servicemen and physicians. Its first commanding officer was Doctor Francis L. Wheaton, son of Doctor Levi Wheaton, a graduate of Brown University Medical School and surgeon in the United States Volunteers. Doctor Lewis A. Edwards, Surgeon U.S.A., who succeeded him as commanding officer, was unanimously elected on June 1, 1864, an honorary member of the Rhode Island Medical Society, attesting to the cordiality existing between the local profession and the neighboring military medical officers, a relationship which happily is still evident.

Doctors Appeal for City Hospital

On December 10, 1851, a committee of physicians headed by Doctor Usher Parsons addressed the following letter to the taxpayers of Providence:

"Sirs:

"The physicians of Providence have long felt the want of a Hospital in this City for the reception of patients who require medical and surgical treatment, and who are not otherwise provided for. They meet with such patients in their professional walks daily whilst to the public generally their great number rarely becomes known. . . .

"It is true that some patients receive aid from the Dispensary, and still more from the gratuitous services of Physicians and some few are sent to the Dexter Asylum. But there are others, badly lodged, often in garrets or cellars, without light or ventilation, and open to the storms of winter, who if honest are harassed by the idea of accumulating rent, are destitute of wholesome food and fuel, and unable to obtain good nursing. Under such circumstances a hospital for their reception, when suddenly overtaken with grave disease or severe injuries would not only supply what is needed, but would actually preserve many lives.

"Again, there are persons of good and industrious habits, who meet with sickness or injury just as they are entering into life, and who have not had time to prepare for such a calamity. . . . Such persons may fall from buildings, be wounded on railroads, or in attempts to extinguish fires in our City, who in other cities are conveyed to a good hospital to receive the best medical or surgical aid, but in Providence are carried to a crowded garret or cellar, where they prefer suffering many privations during a lingering cure, and incurring heavy expenses to be paid for by future earnings, to being carried to the Dexter Asylum, to dwell with paupers and the victims of debauchery. The Asylum, however spacious and well adapted it may have been ten years ago, is now crowded with the offscourings of Europe, and patients cannot receive proper treatment without such a change in its arrangements as would be incompatible with its ordinary or legitimate uses.

"At the present, many persons afflicted with chronic diseases, and requiring skillful operations and treatment, go from our City and State to the well-established hospitals of Boston and New York; and many others would avail themselves of that high privilege, but for want of means. These, certainly, ought to be provided for within our own State. . . .

"As an earnest of their readiness to aid in supporting a hospital, they engage to serve it gratuitously as physicians or surgeons, whenever they are required."

This communication reached every taxpayer who was assessed to pay a tax of $100 or more. The letter is interesting in several respects. It emphasized the marked impact of the recent industrial revolution on the economy and upon the way of life in the city and state. A further complicating factor was the flood tide of immigration from Europe which was having obvious effect upon the numbers of sick poor requiring attention from the local medical community. The inclination of the well-to-do to travel to neghboring large cities for treatment has a strangely familiar ring, and obviously caused the profession some chagrin. Undoubtedly, however, the plaintive reference to "that high privilege" was largely inspired by altruistic motives.

This broadside produced no immediate reaction. Consequently, in the following year a petition was presented to the city government using much of the same phraseology. The following remarks were added: "No city of the population and wealth of Providence has deferred so long a time to provide a public hospital. . . . We respectfully beg leave to recommend that a hospital be provided by the city, to be sustained by private subscriptions. . . . We hope that you will appropriate . . . some . . . suitable place for a hospital, on condition that fifty thousand dollars be raised by private subscription." The City government in answer to this request appointed a committee to meet with the physicians to examine the facts. There followed considerable further delay during which the relative merits of the Tockwotton estate and the "od hospital lot" were weighed.

Moses Brown Ives, who died in 1857, left $50,000 in trust for public benefactions. After otherwise disposing of some $10,000, the trustees were finally persuaded in 1863 to make the remain-

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The RHODE ISLAND MEDICAL JOURNAL

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MEDICAL EDUCATION

In the September number of the JOURNAL Doctor Seebert J. Goldowsky presented the first of three papers on the history of medicine in Rhode Island. We have a feeling that the modern doctor should have a little more background than he seems usually desirous of obtaining. It would save a lot of trouble. One of the much advertised modern pieces of impedimenta was essentially developed six hundred years before Christ and promptly forgotten.

From its beginning when Doctor William Hunter, a cousin of the famous eighteenth century Hunter Brothers of England, started practicing in Newport, Rhode Island has had a most excellent medical history. Doctor Benjamin Waterhouse, of Newport, gave us a lot of good information about the early physicians. He, appointed in 1782 Professor of the Theory and Practice of Physic at The Harvard Medical School, was, despite his failings, a great physician who was responsible for the introduction of smallpox vaccination in America. Doctor Usher Parsons, Naval hero surgeon of the Battle of Lake Erie, and Doctor Solomon Drowne, who developed his most interesting botanical garden at Mount Hygeia in Foster, were brilliant members of the ill-fated Brown Medical School. More of that caliber were not uncommon in Rhode Island's medical history. We feel that we are fortunate in having this careful and interesting story brought to us by Doctor Goldowsky, and we trust that you will all do yourself a lot of good by reading it.

TELEPHONE LISTINGS

The action of the House of Delegates in clarifying the local situation regarding telephone and other directory listings is published elsewhere in this issue (see House of Delegates, Committee on Public Relations, page 647). The question of how specialties should be publicized, and to what extent, has been subject to review by many medical societies throughout the country during the past year. Twice our Society made rulings on the matter, and in neither instance was the issue completely resolved.

The current action of the House of Delegates is based on a comprehensive study by the Society's committee on public policy and relations that included a report on the entire problem of so-called physician advertising.

The adoption of these new regulations should be recognized as an effort to assist the public primarily, particularly in view of the increasing number of physicians who now enter medical practice limiting their work to a restricted field of service.

All directory listings must be limited by the specialty classifications posted by the Society in its annual roster (see October issue of the R. I. MEDICAL JOURNAL), and they are subject in addition to final approval by the committee on public policy and information.

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The House rulings on newspaper announcements, office signs, and program displays merely establish as written regulations the procedures that have been generally recognized by most physicians through the years.

THE DOCTOR MICHAEL H. SULLIVAN SCHOOL

Late last August the people of the city of Newport joined with their school committee for the dedication of one of the newest schools in the state —an elementary school that will also serve as a training school for students of Salve Regina College who are entering the teaching profession—in the name of Dr. Michael H. Sullivan, dean of the active physicians of Rhode Island, and a past president of our Society.

For fifty-four years Doctor Sullivan has engaged in the general practice of medicine, and for more than fifty of those years he has been chief of obstetrics at Newport General hospital. In 1953 he was cited by our Society as the "Practitioner of the Year," and he was lauded by the General Assembly and the City Council of his own city. And when the laudatory speeches had been said, the tributes paid, and the awards given, Doctor Sullivan resumed the daily rounds of his medical practice unchanged not the least by it all.

And now a living memorial has been created for one of the most beloved physicians in the state, and we suspect that it is the kind of a memorial that Doctor Sullivan likes best, for he has been the physician at hand for more than 15,000 births in his Newport area, and he has watched his thousands of children grow up. Doctor Sullivan cannot be eulogized adequately in type, as his hometown newspaper pointedly stated in 1953 when it remarked "print cannot reveal the gratitude people feel for the man who has been physician and friend and counselor and helper, so how can you write an editorial about a man whose greatest editorial is written in the hearts of the people of the city he has loved and that loves him."

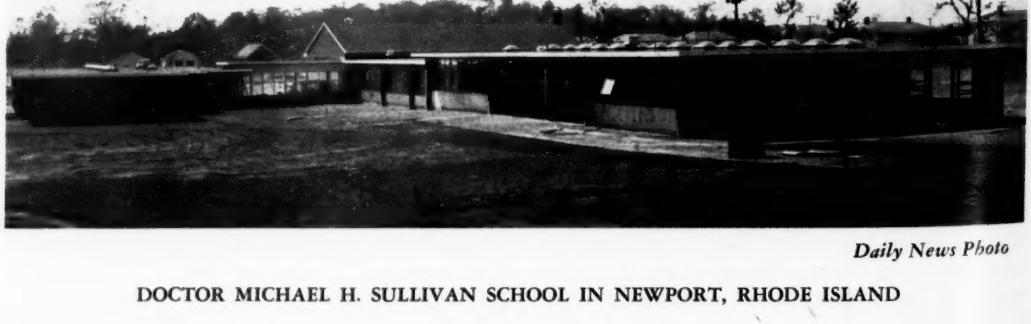
But Newport has found an admirable public expression for her favorite physician, and the handsome half million dollar building near the Middletown boundary line will be a fitting tribute to a truly remarkable man.

CARE OF EXPERIMENTAL ANIMALS

We get many a request to announce meetings and we have to let most of them, which are not particularly pertinent to our particular organization, go by unnoticed. However, we are pleased to announce the forthcoming meeting of the Animal Care Panel on December 1st and 2d, at the Henry Hudson Hotel (353 West 57th Street), New York City.

The Animal Care Panel is an organization of investigators, administrators of animal quarters, animal breeders, food and cage manufacturers; in short, individuals interested in the care of experimental animals. The program will consist of papers dealing with the physiology and behavior of laboratory animals, their diseases, nutrition and related problems.

The anti-vivisectionists have striven hard to make the public believe that we seize any stray animals which we may find and torture them chiefly because of our sadistic leanings. We do not believe that any intelligent people really believe this, but constant reiteration may fool the public. Of course, there is no truth in this. First of all, most of the animals used in experiments have pedigrees that would make the Kings of England look like upstarts. When any of these experiments are started, it is a pretty miserable thing to lose any of these important animals. Therefore, we presume that no human beings get the perfect care that these animals get. We doubt if any of you go down to New York, but we should emphasize the extreme care these animals are getting.



Daily News Photo

DOCTOR MICHAEL H. SULLIVAN SCHOOL IN NEWPORT, RHODE ISLAND

TO ALL MY PATIENTS

The new A.M.A. pamphlet, titled *To All My Patients* has been distributed to all members of the Association. It is a fine public relations aid to your medical practice that should be made available to your patients.

The attractive twelve-page pamphlet describes briefly the responsibilities of various persons on the medical team, it discusses medical fees and health insurance, and it encourages a friendly discussion of medical services and the fees charged for them.

We know that physicians find their mail padded with literally hundreds of brochures, pamphlets, and leaflets emanating from many sources, and all for the most part seeking to sell the doctor some product or service. The pamphlet *To All My Patients* should be read by every doctor, and copies should be ordered from the A.M.A., or through the state society executive office, for distribution to your patients. The pamphlet may be left on waiting room tables, or it may be mailed by you to your patients since space has been provided on the back cover for you to imprint your name, or a mailing address.

Here is a fine new approach to help you and your patients achieve that mutual undestanding so important to a successful doctor-patient relationship!

FUNDS FOR MEDICAL EDUCATION

The medical profession pledged two million dollars annually in 1951 to assist the nation's medical schools, and through the efforts of the American Medical Education Foundation more than one million of that fund has been subscribed in each of the past two years.

Recently every physician received a special appeal signed by Doctor Hess, president of the American Medical Association, urging continued support of the program. The record shows that Rhode Island physicians have contributed liberally to medical school aid in recent years, although the bulk of such contributions has been through direct mailings to the schools rather than through the AMEF.

Several state medical societies, including our neighbor, Massachusetts, have contributed gifts from their society treasury to aid the campaign. Some states have made special assessments for the same purpose. We have not felt that a special tax is necessary upon our membership, and the record indicates to the contrary that Rhode Island physicians individually have supported medical education through voluntary contributions to their respective schools.

But the situation in 1955 calls for increased individual assistance to maintain our high medical teaching standards without Federal subsidies, as has been advocated in some quarters. We are encouraged by the active support that industry has given in recent years to further interest in college and professional school training. We believe that this spirit of cooperation should be strengthened, and the best way to strengthen it would be for higher individual donations by physicians to set the example for giving by others.

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BEGINNINGS OF MEDICAL EDUCATION IN R. I.

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ing $40,000 available for hospital purposes. To this was added $10,000 by his son, Captain Thomas Poynton Ives. Thereupon the legislature granted a suitable charter and the City of Providence appropriated the site of the old Marine Hospital, popularly referred to as "Hospital Park." Upon issuance of the charter the list of corporators, which had previously contained the names of doctors exclusively, was enlarged by the addition of two hundred names, "mostly non-professional gentlemen." A highly successful subscription campaign followed, to which Doctor Parsons himself contributed one thousand dollars.

Medical Society Action

At its annual meeting on June 3, 1863, the Rhode Island Medical Society passed the following resolution: "That this society view with the deepest interest the successful progress of the movement for the foundation of a Rhode Island Hospital,—a movement which began with the medical profession of the City of Providence, but has now been enlarged to embrace the whole state within the scope of its beneficent operations; and we promise the corporators of the hospital all the aid and influence we can furnish in its behalf, as physicians and citizens."

This was followed by the submission to the Society of a request for a "committee with whom the committee on plans of this board may consult with regard to the construction and arrangements of the hospital buildings." The Society acknowledged this request and appointed such a committee on December 16, 1863. On June 1, 1864, at the annual meeting, it was reported that this group had submitted to the committee on plans "a detailed report in writing."

Rhode Island Hospital Opened

It is not germaine to the title of this paper to go further into the plans and building of the new hospital. Suffice it to say that no pains or expense were spared to provide the community with the most modern institution that the technology of the period could provide. The exercises celebrating the opening of the new and imposing edifice took place on October 1, 1868. The following are excerpts from the remarks of Professor William Gammell of Brown, the orator upon that impressive occasion:

"The need of a General Hospital for the sick and the injured in the midst of a population so largely employed in the mechanical arts, was first urged upon public attention in this city by the gentlemen of the medical profession, who, better than any others, know how much life was lost, because there was no such institution here. In October 1851, the Providence Medical Association appointed a committee of their fraternity to consider the subject, and to report a mode in which it might most effectually be brought to the consideration of the public. This was done at the instance of their President, Dr. Usher Parsons, our venerable friend, who today beholds the full accomplishment of all his benevolent plans."

He referred to the grounds as "this beautiful and salubrious site, which for three-quarters of a century [i.e. since 1789] had been used by the people of Providence for hospital purposes." He stated further: "A hospital must take the lead in all medical departments. Its essential work should be thoroughly done, or it should not be attempted. It has, therefore, been the aspiration of this corporation to have a hospital building that is fully equal to the highest standard of the age and as nearly perfect as can be built. . . .

"The hospitals of Philadelphia, New York and Boston, have made those cities centers of medical education for nearly the whole country. And with the aid of the Rhode Island Hospital, why may we not have a Rhode Island Medical School again associated with our own University, as there used to be some forty years ago. Indeed even without any formal establishment for the purpose, the Hospital will be, in itself, a school of practical medicine of the greatest importance to the profession. It will concentrate a knowledge of every form of disease; it will bring together the results of varied experience; it will stimulate ingenuity, and suggest improvements and discoveries." These were indeed prophetic words.

At the annual meeting of the hospital on November 10, 1868, the president, Robert H. Ives, reported: "On Tuesday, the 6th of October, the Hospital received its first patient. It was a case requiring a very severe surgical operation, which was successfully performed on the following Saturday, by the Visiting Surgeon in attendance, Dr. Mason, and in the presence of the Consulting Surgeons, who were summoned from all parts of the State. The patient is favorably progressing toward recovery." This apparently was quite an event.*

*This patient was a 59-year-old shoemaker named John Sutherland presenting necrosis of the upper jaw. Disease of the antrum was suspected. The maxilla was resected and the antrum was cleaned out. The specimen was examined microscopically (presumably without staining) and the impression of malignancy was confirmed. The patient made an uneventful convalescence and was discharged on December 7, two months following admission. We could not do much better today.

The second surgical admission was a 55-year-old Irish servant who was treated for a varicose ulcer with bed rest and wet dressings. She was discharged healed after three months.

The first medical admission was a 49-year-old German gunsmith presenting "articular rheumatism." He was discharged after five weeks unimproved. These cases have a hauntingly familiar sound.

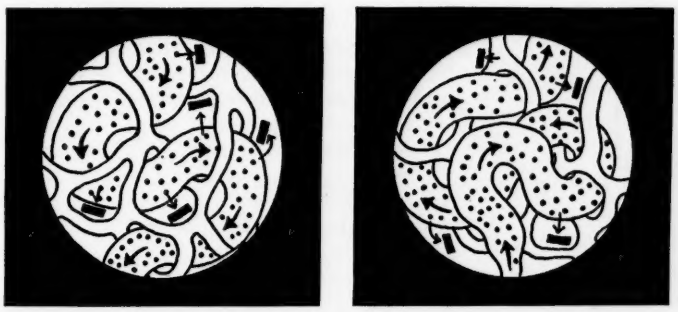
continued on page 640

MICTINE*—THE NEW ORAL DIURETIC

Searle MICTINE Provides Effective Oral, Non-Mercurial Diuresis

The result of many years of research, Mictine, brand of aminometramide, supplies a long-felt need for an improved oral diuretic. Mictine, 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione, is not a mercurial, xanthine or sulfonamide.

Effectiveness: Every method for measuring the diuretic effect in man now available, including precise human bioassay studies, without exception demonstrated that Mictine is an effective oral diuretic, and these studies show that approximately 70 per cent of *unselected* edematous patients treated with Mictine by mouth respond with a satisfactory diuresis.



Mictine is believed to act by the selective inhibition of the reabsorption of sodium ions. Thus, the resulting diuresis is characterized by increased quantities of sodium ions and water.

Well-Tolerated: There are no known contraindications to Mictine, even in the presence of hepatic or renal damage, and there is no risk of acidosis. On high dosage, Mictine causes some side effects in some patients but on three tablets daily these side effects (anorexia and nausea, rarely vomiting, diarrhea or headache) are minimal or absent.

Indications: Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. Mictine may be used also for *initial and continuing* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated.

Administration: The usual dosage for the average patient is one to four tablets daily with meals, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days or for three consecutive days and then omitting it for four days.

For severe congestive states the dosage is four to six tablets daily with meals, in divided doses on interrupted schedules similar to those already mentioned.

Supplied: Uncoated tablets of 200 mg.

**Trademark of G. D. Searle & Co.*

SEARLE

BEGINNINGS OF MEDICAL EDUCATION IN R. I.

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Hospital Library Developed

The plans for the new hospital provided space for a library and for a lecture room. In the annual report of November 9, 1864, appears the following statement: "The Library of the late Dr. Ezekiel Fowler, of Woonsocket, in this State, bequeathed by him to the Rhode Island Hospital, has been received, and is now in the custody of the Board. The Library consists of about four hundred volumes of medical, surgical, biographical and miscellaneous works. It will serve as a timely and valuable commencement of a Hospital Library, which it is hoped will continue to receive accessions by donations from other friends of the Institution." Here is good evidence that the trustees were deeply interested in the problem of education even before the new hospital opened its doors. In the annual report of November 13, 1867, the bequest of one hundred volumes "of the more recent standard works" from the library of the late Doctor J. Davis Jones was announced. He had died prematurely at the age of twenty-eight. This donation was "highly appreciated as the gift of a young man who understood its importance to the Medical and Surgical Departments of the Hospital. . . . We earnestly commend to public notice this instance of thoughtful liberality at the commencement of our active operations as a Hospital. The large and beautiful room designed for the library and the museum, will be ready for occupancy in the course of a few weeks. Valuable books, specimens of morbid Anatomy, well executed Anatomical drawings and models, Pathological specimens and like means of illustrations will be timely and most acceptable presents, and will add largely to the usefulness of the Institution."

Additional gifts of books at the time of the opening of the hospital brought the total to some 1400 volumes, including 300 from the library of Doctor Usher Parsons. One contribution included "upwards of three hundred volumes, mostly in the French language, and a black walnut case for the same" and another "a cabinet of very choice pathological specimens."

On December 16, 1868, shortly after the hospital had started operations, the Rhode Island Medical Society voted: "That all books, instruments and apparatus belonging to the Society, and now in the hands of the Cabinet Keepers, and Librarians: also, any preparations belonging to the Society, be, and they hereby are, presented to the Rhode Island Hospital; provided, the members of this Society shall be permitted to have free use of them when desired, subject to the rules of the hospital." This contribution included the original gift of 72 volumes from the library of Doctor Caleb Fiske. By 1874 the hospital librarian, Doctor Charles L. Leonard, was able to report that the library had increased to 2000 volumes. The fate of this historically valuable collection is an unhappy one. Some time during the year 1930, prior to the opening of Peters House, the new residence building for interns and residents, Doctor John M. Peters, then superintendent of Rhode Island Hospital, felt the need of disposing of the outmoded books in order to provide additional space for other hospital services. Unfortunately he appears to have been rather unsentimental with respect to the historical value of old books and prepared forthwith to sell them for waste paper. A few discerning individuals salvaged some of the more valuable specimens. The rest of the library was scattered. The Rhode Island Medical Society to which many rightfully belonged appears to have been left out.

One other note is of interest. In the Annual Report of November 10, 1869, appeared the following ruling: "The Trustees may grant any practitioner or student of medicine, of one year's standing, a ticket of admission to follow the practice of the Hospital for not more than one year."

Doctor Usher Parsons, a surviving link with an earlier excursion into medical education, lived to see his dream realized. He was able to attend the opening exercises of the hospital on October 1, 1868. Wrote his son, Professor Charles W. Parsons: "He was conducted to a seat on the platform, and was kindly referred to in Professor Gammell's eloquent discourse [see above]. This compliment, the last he was ever to receive on any public occasion, gratified him very much. He wrote in his diary the next day, with a trembling hand, 'I feel very happy for yesterday's doings.' He was present at the first important surgical operation performed there, October 10 [as Chief of Consultants]." His death occurred two months later.

Medical School Hopes Revived

The hope expressed by Professor Gammell that Rhode Island might yet see another medical school was to linger on. Wrote Professor Parsons in 1881 in his history of Brown University Medical School: "There has been no medical department in this institution since the advent of President Wayland, and for almost fifty years there was no medical man on the Faculty. . . . Whether a medical school will ever be revived here, is a question not of history, but of very doubtful forecast. Providence, from a town of 15,000 inhabitants, has grown into a city of more than 100,000. It contains a Hospital and Dispensary, both furnishing opportunities for clinical instruction far surpassing any that the Professor of Theory and Practice of Medicine could command in Dr. Messer's time. The University has for several years shown great hospitality to those physical sciences which are tributary to the medical art, . . . zoology, botany, chemistry and

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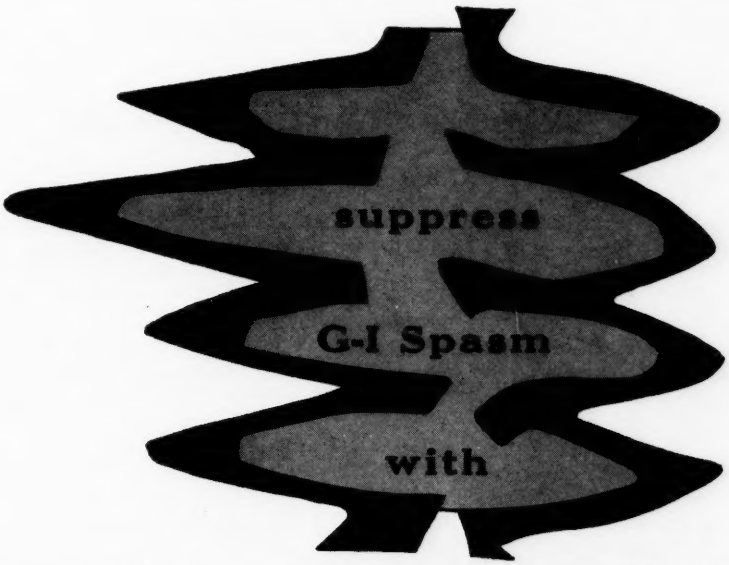

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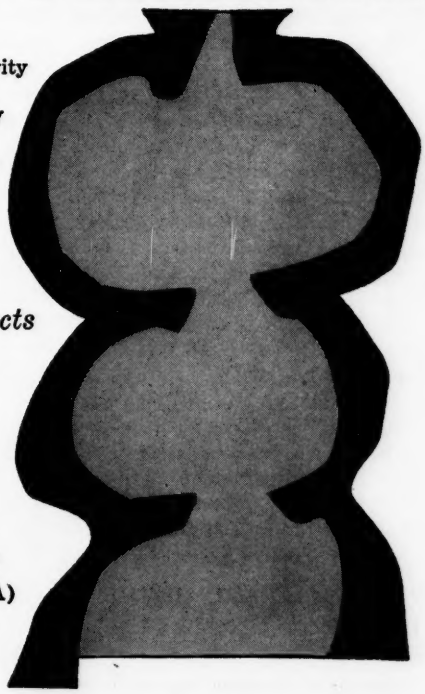

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting, September 28, 1955

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 28, 1955. The meeting was called to order by the president, Frank B. Cutts, M.D., at 8:15 P.M. The following delegates were in attendance:

KENT COUNTY: Edmund C. Hackman, M.D.; Russell P. Hager, M.D. *NEWPORT COUNTY:* Henry W. Brownell, M.D. *PAWTUCKET DISTRICT:* Robert C. Hayes, M.D.; Henry E. Turner, M.D.; Harold A. Woodcome, M.D.; Hrad H. Zolmian, M.D. *WASHINGTON COUNTY:* James A. McGrath, M.D. *PROVIDENCE MEDICAL:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Wilfred I. Carney, M.D.; William B. Cohen, M.D.; Edmund B. Curran, M.D.; John A. Dillon, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; John C. Ham, M.D.; Hannibal Hamlin, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; Louis A. Sage, M.D.; Lee G. Sannella, M.D.; William J. Schwab, M.D.; George W. Waterman, M.D. *OFFICERS OF THE RIMS (other than delegates):* Frank B. Cutts, M.D.; Thomas Perry, Jr., M.D.; John G. Walsh, M.D. *IMMEDIATE PAST PRESIDENT OF THE R. I. MEDICAL SOCIETY (without vote):* Henri E. Gauthier, M.D. *WOONSOCKET DISTRICT:* Francis P. Vose, M.D.

Also in attendance were Doctors John T. Barrett, chairman of the Child and School Health Relations Committee; David Freedman, trustee of the Benevolence Fund; Earl J. Mara, chairman of the Social Welfare Committee; Francis B. Sargent, chairman of the Group Liability Insurance Committee; and John E. Farrell, Sc.D., Executive Secretary.

REPORT OF THE CHILD AND SCHOOL HEALTH RELATIONS COMMITTEE

Dr. John T. Barrett, chairman of the Child and School Health Relations Committee, reported on the status of the distribution of polio vaccine in Rhode Island. He related the development of the State Advisory Committee, and he briefly reviewed the meetings held by this Committee. He indicated that in view of the federal regulations restricting the use of the vaccine received by the state on a matching fund basis, the Committee had accepted the ruling that children in the age group, 5 to 9, should receive first priority, then the age group, 1 to 5, after which pregnant women and other adults would be eligible. He stated that $135,000 had been allocated to the state of Rhode Island to be used prior to next June, and this amount would purchase approximately 150,000 cc. of the vaccine. No means test is to be included in the distribution which is to be carried out in clinics established by the State Department of Health. Dr. Barrett stated that the small quantity of vaccine available at the present time forced the decision to handle all of it presently through the public agencies.

Action: The report was discussed briefly by the members of the House after which the sentiment of the House was expressed that the Child and School Health Relations Committee should issue any statement necessary regarding the distribution of the polio vaccine in Rhode Island for publication in the RHODE ISLAND MEDICAL JOURNAL for the information of the members.

MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the House of Delegates, distributed in mimeographed form to each member and subsequently published in the RHODE ISLAND MEDICAL JOURNAL, were approved for permanent file.

REPORT OF THE SECRETARY

Dr. Thomas Perry, Jr., secretary of the Society, submitted the following report:

The council has held one meeting since the last meeting of the House of Delegates. Among matters resolved were the following:

1. The report of the trustees of the Caleb Fiske Fund was received relative to the 1955 prize dissertation, and approved.
2. The Council was notified that the request of the Society to the American Medical Association that AMA dues be assessed directly from its Chicago headquarters office would entail a bylaw change for the Association not contemplated at this time.
3. Dr. Francis V. Corrigan, Chief of the Division of Maternal and Child Health of the

continued on page 644

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Ulcer protection that lasts all night:

Pamine syrup

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REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF METHSCOPOLAMINE

Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide
1.25 mg.

Dosage:
1 to 2 teaspoonfuls three or four times daily.

Supplied:
Bottles of 4 fluidounces.

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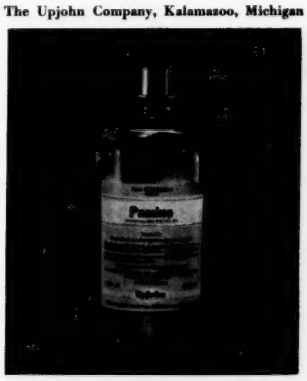

HOUSE OF DELEGATES

continued from page 642

Rhode Island State Department of Health, was designated to represent the Society at the Fifth National Conference on Physicians and Schools to be held at Highland Park, Illinois, in October, if he finds it possible to attend the meeting.

4. Dr. Charles J. Ashworth, Chairman of the Society's Committee on Federal Medical Services, and the Executive Secretary were designated as official delegates of the Society to a regional legislative conference under the auspices of the American Medical Association to be held in New York City on October 29 and 30.
5. Dr. Walter E. Campbell, Chairman of the Society's Committee on Mental Health, was designated as the Society's official delegate to the Second National Conference of State Society Representatives to confer on mental health problems, the meeting to be held in Chicago in November.
6. A resolution adopted at the Annual Meeting of the Rhode Island Pharmaceutical Association was referred to the Society's Committee on Medical-Pharmaceutical Relations.
7. A special report from the Committee on Medical Defense and Grievance was received and placed on file.
8. The Committee on Mental Health of the Society was asked to confer with Butler Hospital authorities relative to the storage and availability to Rhode Island physicians of the medical records of the Hospital.
9. The Committees on Medical Economics and Social Welfare were asked to give consideration to a review of the Uniform Fee Schedule for Governmental Agencies first adopted in 1950.
10. The Board of Trustees were requested to secure estimates for the costs of necessary improvements to the Library building.
11. The Board of Trustees of the Library were authorized to place an appropriate marker on the lectern in the Library auditorium to indicate that it is a gift of Dr. Stanley Freedman of Providence.
12. A proposed budget for the Society for 1956, as submitted by the Treasurer, was approved.
13. The Treasurer was instructed to transfer to the Agency Account of the Society the bequest from the Estate of the Late Dr. Jesse E. Mowry for investment.
14. A committee was authorized to study recommendations made by the Chairman of the Library Committee and to report to the Council at a future date.
15. Membership of the Society in the Council of the New England State Medical Societies was renewed, and Drs. Frank B. Cutts, Charles J. Ashworth and Thomas Perry, Jr., were named as the Society's official delegates to this Council.
16. The State Director of Health was requested to recall from circulation the booklet issued recently by the Department listing a registrar of physicians in Rhode Island for the reason that it lists specialty designations which are not accurate and which should not be listed in such a publication, it has many errors, and it lists osteopathic physicians in the registrar of doctors of medicine.

Action: It was moved that the report of the Secretary be received and approved and the actions taken by the Council, as reported, be approved. The motion was seconded and adopted.

Recommendation from the Council

The Secretary reported the following recommendation from the Council:

To meet the anticipated expenses of the Society as proposed in the budget for 1956, the Council recommends that the dues in 1956 for active Fellows be $50, except that Fellows in their first year of practice shall pay dues of $25.

Action: It was moved to adopt the recommendation. The motion was seconded and adopted.

Report of the Treasurer

Dr. John A. Dillon, Treasurer of the Society, submitted the following report:

With the death this summer of the widow of Dr. Jesse E. Mowry, onetime president, and for nineteen years Treasurer of the Society, the Rhode Island Medical Society received 5% of his trust estate to be held in trust as the Jesse E. Mowry Fund, the income from which is to be used toward current expenses of the Society. The trust amounted to $6,131.54, which has been turned over to our Agency, the Industrial Trust Company, for investment in accordance with the action taken by

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the Council at its recent meeting.

The proposed budget for the Society approved by the Council is predicated on our experiences of the past few years, and it duplicates to a great extent our current budget for this year. The anticipated receipts from all sources are expected to be about $44,000 and our anticipated expenses will be approximately $42,000 with an anticipated $1800 held for a contingency fund.

The improvements to the Library building initiated last year when the annual assessment was increased primarily for that purpose, will be continued in the coming months, as the Trustees of the Library building have indicated that our property is in need of many improvements.

Action: It was moved that the report of the Treasurer be received and approved. The motion was seconded and adopted.

Communications

The Secretary reported receipt of a communication from the Pawtucket Medical Association regarding the Society's poll relative to Social Security coverage for physicians.

The Secretary read the results of the poll, as previously reported to the members of the House of Delegates individually, and he explained at length the position of the American Medical Association relative to Social Security coverage for physicians.

Committee on Group Liability Insurance

Dr. Francis B. Sargent, Chairman of the Committee on Group Liability Insurance, reported that the Society's program had enrolled 148 members, but that 43 had been rejected because of the insurance company's underwriting regulations. He discussed the problem as presented by the insurance company regarding coverage for anesthetists, radiologists and psychiatrists. He expressed the hope that the gradual development of the program would make it possible within a year to authorize coverage for every physician regardless of his specialty.

Action: It was moved that the report of the Group Liability Insurance Committee be approved as presented. The motion was seconded and adopted.

Committee on Social Welfare

Dr. Earl J. Mara, Chairman of the Committee on Social Welfare, reported that several meetings had been held of his Committee to revise the 1952 Provisions for the Purchase of Physicians' Service from the Public Assistance Funds. He reviewed many of the problems discussed and resolved by his Committee and the State Department of Social Welfare, and he called attention to the new brochure which had been issued to the membership of the Society effective September 1, 1955.

Dr. Cutts commended Dr. Mara and his Com-

continued on next page

Two Gentlemen Are Waiting to Hear From You

The names are "Santa Claus" and "Uncle Sam" each with a problem for you. We have helpful suggestions to make both problems much easier.

First, what to give your wife for Christmas? If you're thinking of giving a check, why not be more imaginative and, instead, give her some shares of good dividend-paying stock? Remember, any woman loves to have income of her own, even a small income. It means money she can spend without having to ask you for it. We'll gladly suggest some good stocks priced for any amount you want to give.

Second, taxes. You'll want to look over your securities for possible 1955 Income Tax savings before the December 31 deadline. Here again, we can help. We'll gladly provide any security prices and market facts you need to evaluate your position and make accurate computations. No charge, no obligation, naturally. Just write, phone or stop in.

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℞ Toclase
Expectorant
Compound
4 ounces
Sig: 1 teaspoonful
3 times daily

mittee for the excellent work it has done in adjudicating problems between the profession and the State Department of Social Welfare.

Action: It was moved that the report of the Committee on Social Welfare be approved as presented. The motion was seconded and adopted.

Chemotherapy for Patients with Tuberculosis

Dr. John C. Ham submitted the following report of the meeting held on August 17th at the State Department of Health which the Medical Director of the State Division of Tuberculosis Control had requested him to present to the Society for possible endorsement. The report is as follows:

It is noted that there has been an increasing concern regarding chemotherapy for patients with tuberculosis on an out-patient basis. We have been confronted with the problem of open cases of tuberculosis refusing hospitalization on the basis that chemotherapy could be provided by private physicians outside the sanatorium. In order to obtain the best medical thought regarding this problem a meeting was called by the Director of the State Division of Tuberculosis Control in the Rhode Island Department of Health of representative physicians and social workers in this field.

Representatives of official health and welfare agencies are generally agreed that ambulatory home treatment of tuberculosis is not an ideal one. Therefore, we cannot rightfully expend State funds to encourage patients to reject the use of the excellent sanatorium facilities available in this State, and thereby continue as potential sources of infection in the community.

On the other hand, it would be unfair to withhold such treatment from deserving patients who are temperamentally unable to adapt themselves to sanatorium life. It would also be unfair to the community to treat the so-called recalcitrant patient as an outcast and deprive him of the benefits of home treatment merely because of his unwillingness to cooperate. Such treatment will, in a number of cases, bring the disease under control to the ultimate benefit of both the individual and the community.

The outcome of this meeting, therefore, was a unanimous agreement that drugs for ambulatory chemotherapy should be made available to all patients, provided certain basic requirements are satisfied; namely:

1. That the disease is reported to the Rhode Island State Department of Health.
2. That the patient is under the continuous medical supervision of a licensed physician.
3. That the patient is financially unable to purchase the needed drugs.
4. That the patient's condition is periodically reviewed at intervals of not longer than four months by the Division of Tuberculosis Control, or by an examiner approved by said Division. This particular review shall consist

you get... specific control of the hyperactive cough reflex without undesirable opiate effects

with new, non-narcotic, non-opiate

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Brand of carbetapentane citrate

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of a chest X-ray and a sputum examination as a minimum requirement.

5. That reports of this particular review by the Director of Tuberculosis Control, or by the approved examiner, be sent to the paying agency and attending physician.

Action: It was moved by the House of Delegates that the report as submitted and the recommendations incorporated therein be approved. The motion was seconded and adopted.

Report of the Committee on Public Relations

Dr. Arnold Porter, Chairman of the Committee on Public Relations, submitted the report of his Committee as follows:

At its April, 1955, meeting the House of Delegates referred to the Committee on Public Policy and Relations the recommendation it had received from the Providence Medical Association requesting that the entire problem of physician advertising, with particular reference to office display signs, telephone directory listings, newspaper displays, etc., be reviewed. This Committee was requested to report to the House of Delegates at its September meeting. Our report follows:

The question of how to list physicians' names in the classified (yellow) pages of telephone directories has been raised frequently by many medical societies. We have made three decisions in as many years on the problem in Rhode Island. It is the general rule that the responsibility for proper listing has traditionally been accepted by the physician himself or by the county medical society since local problems, customs and telephone company policies are more readily understood and, if necessary, adjusted at that level. Hence there is no universal rule in the matter, nor has the AMA taken any action.

In an effort to summarize the picture throughout the country the Public Relations Department of the AMA checked the way in which physicians' names appear in the telephone directories of 90 cities and towns in 33 states, the District of Columbia and Hawaii. A summary of the findings is attached to and made a part of this report.

Your Committee has reviewed the problem of telephone listings, and the allied issues relating to publicizing the physician's name, and it presents the following recommendations for consideration by the House of Delegates:

1. *Telephone and Other Directory Listings:* As an aid to the public specialty listings by physicians should be permitted only on the basis of specialty classification as listed by the RHODE ISLAND MEDICAL JOURNAL, and subject in addition to final approval by the Committee on Public Policy and Relations. All such specialty listings in any public directories should not be in bold type or otherwise prominent display type.

continued on next page

2. *Newspaper Displays:* Newspaper displays should be permitted not to exceed two columns in width and two inches in depth, and not to exceed publication in more than six issues of each newspaper within a one-week period, to announce—
   a. The establishment of an office for the practice of medicine.
   b. To announce a change of office address.
   c. To announce resumption of practice after a term of duty with the Armed Forces of the United States, or after an absence from practice for a period of three or more months, or after a long period of illness.
3. *Office Signs:* Office signs should list only the physician's name and the abbreviation M.D., and should be consistent with local customs and precedents. Specialty listings should not be placed on office signs. Ordinary illumination of office signs is permissible for physicians having night office hours, or residing in urban or rural areas, or where off-street lighting offers poor visibility of the physician's office entrance.
4. *Display Advertisements in Programs, etc.:* The Code of Ethics provides that "solicitation of patients, directly or indirectly, by a physician is unethical." It would appear that some paid display notices in programs, such as those prepared for charity organizations and the like, are a form of indirect solicitation, when the physician's name is listed as the donor of the cost for the display. Such paid displays, in the opinion of the Committee, should not be approved. The listing of a physician as a patron in a list would be permissible.

Action: It was moved that recommendations 2, 3 and 4 be approved by the House of Delegates. The motion was seconded and adopted.

* * *

It was moved that recommendation 1 be adopted. The motion was seconded.

Discussion: There was discussion of this recommendation after which, by request of the House, the President called for a vote by a show of hands. Fourteen (14) voted "Yes" for adoption and twelve (12) voted "No." The recommendation was therefore adopted.

Physicians Service

Dr. Charles J. Ashworth, President of Physicians Service, briefly discussed the addition of X-ray benefits effective October 1, 1955. He expressed the hope that every physician would feel a sense of personal responsibility in seeing that the new benefit is not abused since the expansion of the program represents a major step for Physicians Service.

Report of the Committee on Scientific Work and Annual Meeting

Dr. Henri E. Gauthier, Chairman of this Committee, reported on the program for the Interim Meeting of the Society to be held on October 26, 1955.

He also reported on the Clinical Session of the American Medical Association to be held in Boston on November 29th to December 2nd.

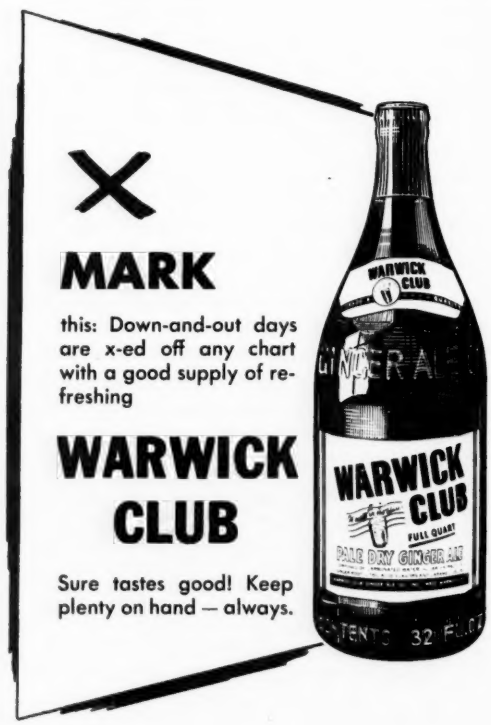
Benevolence Fund

At the request of the President, the Executive Secretary briefly reviewed the history of the proposed Benevolence Fund and he submitted a new indenture drafted by the Legal Counsel.

Dr. David Freedman, one of the original Trustees of the Benevolence Fund, discussed the plans for activating a program and he submitted the following two resolutions:

Resolved: That all prior action of the House of Delegates in approving a Benevolence Fund be and hereby is rescinded, declared void and of no effect.

concluded on page 650



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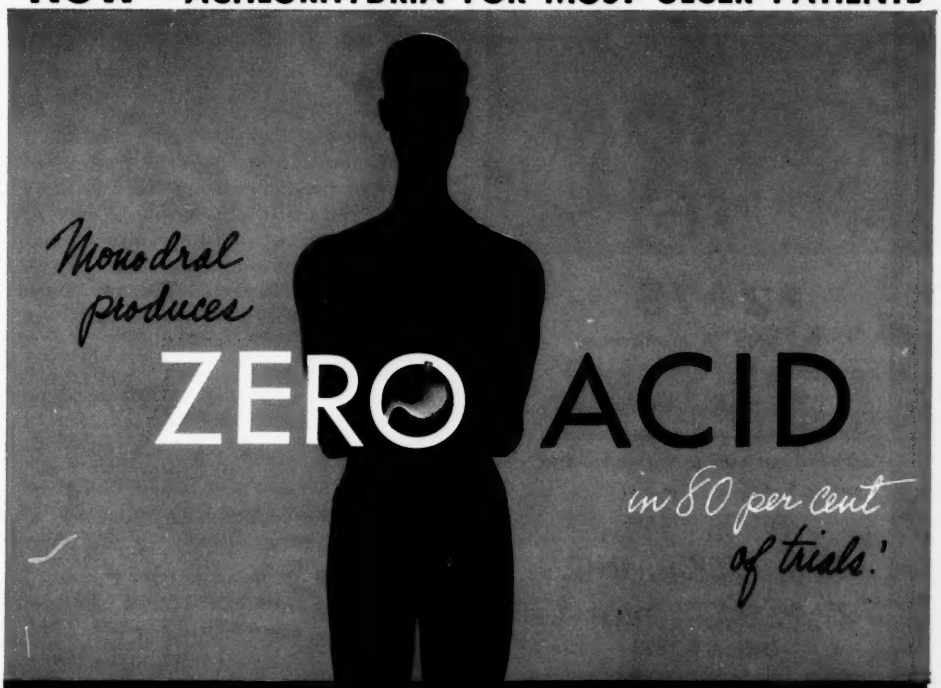

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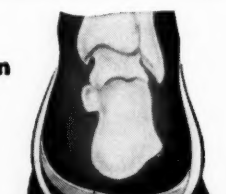

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HOUSE OF DELEGATES

concluded from page 648

Resolved: That the indenture of the Benevolence Fund of the Rhode Island Medical Society substantially in the form presented to this meeting be and hereby is adopted and approved; that a copy attested by the Secretary be attached to the minutes of this meeting; that the President be and hereby is authorized to execute and deliver a copy of the indenture of the Benevolence Fund to the Trustees thereof; and that the following be and hereby are elected Trustees of said Benevolence Fund to hold office for said terms and until their successors are duly qualified and elected: Dr. David Freedman, 3 years; Dr. George W. Waterman, 2 years; and Dr. Henry J. Hanley, 1 year.

Action: It was moved that the recommendations relative to the Benevolence Fund be adopted. The motion was seconded and adopted.

* * *

The meeting adjourned at 10:12 p.m.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

BEGINNINGS OF MEDICAL EDUCATION IN R. I.

continued from page 640

physiology. Its liberal spirit gives assurance that it would welcome the addition of a medical school to its other departments, if the community and the profession should be ready to demand it. . . . Whether this city, the second in New England, shall become the seat of such a school must depend very much on the zeal, persistence and ability of its physicians."

This was not the last. On a visit to Providence in 1899 William Osler delivered the following remarks before the Rhode Island Medical Society: "The existing conditions in Providence are singularly favorable for a small first-class school. Here are college laboratories of physics, chemistry and biology, and modern hospitals with three hundred beds. What is lacking? Neither zeal, persistence nor ability on the part of the physicians, but a generous donation to the University of a million dollars with which to equip and endow laboratories of anatomy, physiology, pathology and hygiene. These alone are lacking; the money should be the least difficult thing to get in this plutocratic town. The day has come for small medical schools in university towns with good clinical facilities."

Evidently the plutocrats failed to take the bait. In 1955 we have an abundance of medical education, but still no medical school.

ACKNOWLEGMENT.—I wish to express my sincere appreciation to Mrs. Helen DeJong of the Rhode Island Medical Society Library and to Miss Marion Brown of the Special Collections Depart-

ment of the John Hay Library at Brown University for their invaluable assistance in bibliographical research. I should like also to remember Miss Marie Clair, my faithful secretary, for her sympathetic criticism and patient attention to detail, and in addition all those who have aided me with the chore of proofreading and with helpful suggestions.

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concluded on page 660

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport Medical Society was called to order at 8:30 P.M. on September 28 by Dr. Robert Bestoso, President.

The meeting took place at the Hotel Viking with twenty-two members attending. The minutes of the previous meeting were read and approved.

The applications to the County Medical Society of Dr. Olga Torres, Dr. Anthony Carrellas and Dr. William F. Thompson were read before the Society and were referred to the Board of Censors.

It was accepted that the payments for the yellow page telephone listings be paid henceforth by the Society and not by the Hospital.

The Secretary was instructed to write to the Fall River Medical Society concerning what was considered as unethical advertising by Fall River practitioners of their specialties in the Newport telephone directory. He was in addition, instructed to send a letter to this effect to the A.M.A.

NEW BUSINESS. A motion was made that the critical situation at the hospital parking lot for doctors be referred to the director of the hospital for serious consideration, and that steps be taken that the parking lot be reserved *unconditionally* for doctors during the morning hours. This was seconded by the Society and passed.

LIAISON COMMITTEE REPORTS. Dr. Callahan wished to be informed of the matters which the Society, as a whole, would be concerned with pertaining to the Physicians Service Plan. It was unanimously agreed that we suggest the plans give the subscribers first day coverage.

Dr. Ceppi wished, in view of difficulties that have already ensued, that a standard procedure for hiring and firing a school doctor be instituted and arranged by the State Committee, and the Secretary be instructed to forward this suggestion to the State Society.

This motion was unanimously passed by the entire Society.

The meeting adjourned at 10:30 P.M.

Respectfully submitted,

JOSÉ M. RAMOS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 3, 1955. The meeting was called to order by the President, Dr. Francis H. Chafee, at 8:30 P.M.

The minutes of the previous meeting were approved as published in the RHODE ISLAND MEDICAL JOURNAL.

Report of the Secretary

Dr. Michael DiMaio, Secretary of the Association, reported the following actions of the Executive Committee:

It approved the appointment by the President of the Association of Drs. Merle M. Potter and Betty Mathieu as the official delegates of the Association at a Providence White House Conference on Education.

It approved the appointment as a liaison committee between the members of the Association and the administrative office and Claims Committee of Physicians Service the following committee: Dr. Joseph Hindle, Dr. Walter S. Jones, and Dr. Ernest K. Landsteiner.

It approved the work of the Association's Committee on Group Health and Accident Insurance, and it commended the Committee for its work in securing additional benefits for the members effective in September.

It approved the following changes in dates for meetings of the Association in coming months:

1. That the December meeting be transferred to Monday, November 28, in order to avoid conflicts with the American Medical Association Interim Session in Boston.

2. That the Annual Meeting be held on Monday, January 9, instead of Monday, January 2, 1956.

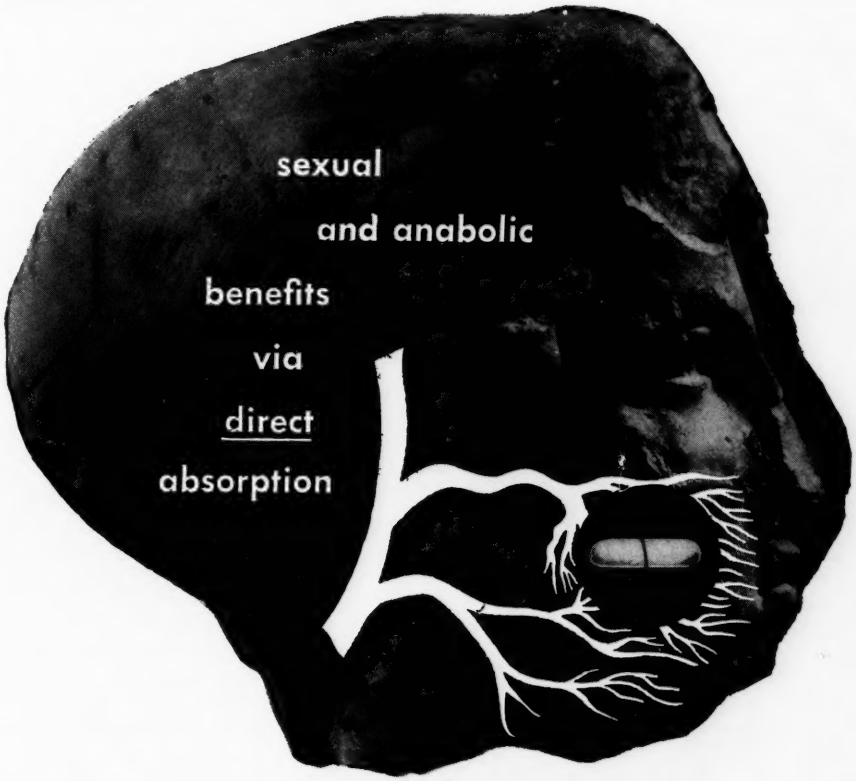
The Executive Committee also approved the appointment by the President of Dr. Joseph G. McWilliams to fill the unexpired term on the Executive Committee of Dr. David J. LaFia, who has moved out of Rhode Island.

Action: It was moved that the report of the Secretary and the actions of the Executive Committee be received and approved. Motion was seconded and adopted.

Report of the President

The President reported that the Secretary is in receipt of obituary tributes to become permanent records of the Association, as follows: to the late

continued on page 654



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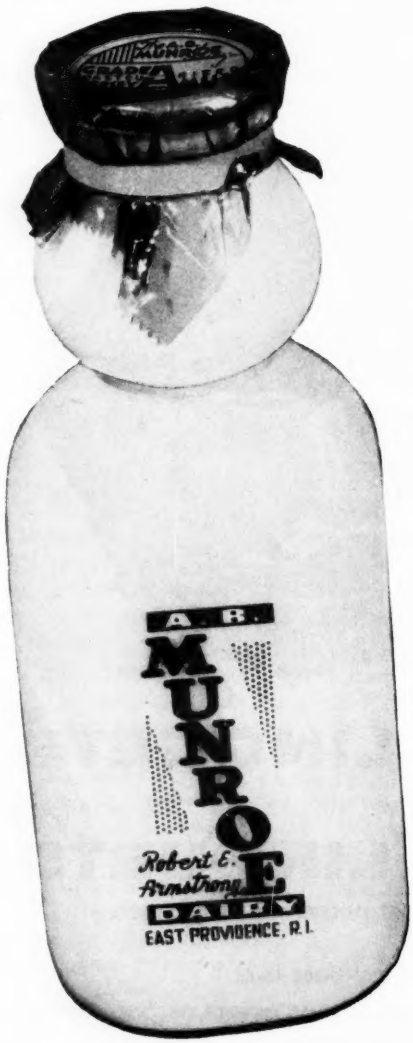

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 652

Doctor George H. Alexander, prepared by Doctors Henry H. Babcock and Arthur H. Ruggles; to the late Doctor John Langdon, prepared by Doctors Henry E. Utter and William P. Buffum; to the late Doctor Harvey B. Sanborn, prepared by Doctors Elihu S. Wing, Sr. and William Newton Hughes; to the late Doctor George L. Shattuck, prepared by Doctors Halsey DeWolf and Herbert G. Partridge.

He also reported that he had named as a committee to prepare the tribute to the late Doctor Joseph C. O'Connell, Doctors John G. Walsh and John E. Donley.

Doctor Chafee called for a moment of silence to the memory of the physicians who died since the last meeting of the Association.

Award of Membership Certificates

The President awarded membership certificates to the physicians elected to active membership in the Association at the April meeting.

Nominations for Membership

The Secretary reported that the Executive Committee recommends for election the following: Paul Arthur Blackmore, M.D., 141 Waterman Street, Providence, Rhode Island, sponsored by: Drs. John Turner II and Michael DiMaio; Joseph E. Caruolo, M.D., 400 Angell Street, Providence, sponsored by: Drs. Edward Cardillo and Hilary H. Connor; Robert E. Newhouse, M.D., 359 Broad Street, Providence, sponsored by: Drs. John A. Rogue and William F. Maher; Joel S. Ordaz, M.D., 81 South Angell Street, Providence, sponsored by: Drs. John F. Gilman and Frederic W. Easton; George Resnevic, M.D., Putnam Pike, Chepachet, sponsored by: Drs. Joseph G. McWilliams and William S. Klutz; Stanislava Resnevic, M.D., Putnam Pike, Chepachet, sponsored by: Drs. Hannibal Hamlin and Thaddeus A. Krolicki; Lester L. Vargas, M.D., 154 Waterman Street, Providence, sponsored by: Drs. Thomas Perry, Jr. and John Turner II.

The Executive Committee also recommends for re-election as an active member of the Society Dr. John A. Picozzi, 358 Broadway, Providence.

Action: It was moved that the recommendations regarding new members in the Association be approved. Motion was seconded and adopted.

Scientific Program

Dr. Chafee presented the panel for the Clinicopathological Conference as follows:

Moderator: Marshall N. Fulton, M.D., Chief of Medical Service, Rhode Island Hospital.

Clinical Discussors: John C. Leonard, M.D., Director of Medical Education, Hartford Hospital; Associate Clinical Professor of Medicine, Yale

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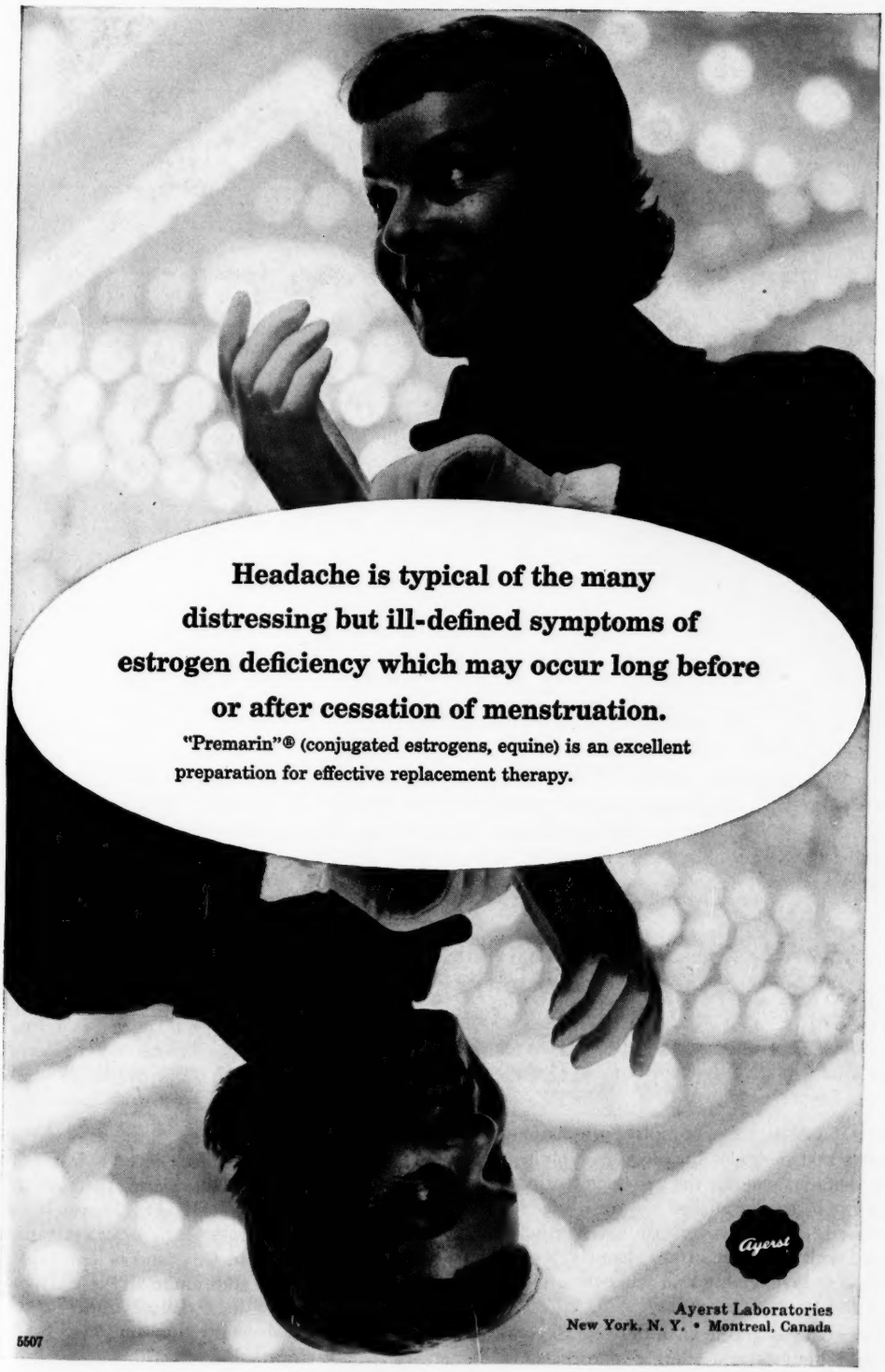
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BOOK REVIEWS

CASIMIR FUNK: PIONEER IN VITAMINS AND HORMONES by Benjamin Harrow. Dodd Mead and Company.

All physicians know that Casimir Funk did some of the earliest work on, and gave the name to, vitamins. Dr. Harrow, who is a chemist and interested in the same type of work that Dr. Funk is, and who is also a great friend of Dr. Funk, has written this book which is almost a eulogy. I think it will be very illuminating to many of the medical profession.

Casimir Funk was a Pole of Russian domination in his youth, but he worked in many of the countries of Europe and got well acquainted with them and their languages, and then worked in this country where he is at the present time. If he is as good as Dr. Harrow thinks he is, and I see no reason to doubt it, he is a remarkable man. He has worked at innumerable projects associated with vitamins which broadly interpreted means that he pretty well covers the field of bio-chemistry, and he has been over and over a pioneer.

The book is divided into two parts. The first largely concerned with his life, and the second with the different problems which he has taken up.

I think the book will be an eye opener to most of the men who read it, and we are delighted to have it in our library.

PETER PINEO CHASE, M.D.

IL SANGUE E GLI ORGANI EMOLINFOPOIETICI NELL' INFEZIONE SIFILITICA (The Blood and the Blood Forming Organs in Syphilis) by Gian Battista Cottini. Editoria Liviana, Padova, 1947

In this 238-page monograph of orientation toward a better knowledge of the blood in syphilis, Cottini says that, in general, the red blood cells and the hemoglobin are diminished and the white blood cells increased. These changes are not specific. It is in accord with Fournier's triad; namely, less erythrocytes, less hemoglobin and leukocytosis. This applies also to prenatal syphilis.

The changes appear as a defense mechanism of reticulo-histiocytary-allergic nature. The bone marrow and the spleen are considerably altered.

The monograph represents an important collection of data. It should be of interest and value to the student of syphilology, who is trying to clarify many uncertain points on the subject of blood and syphilis.

F. RONCHESE, M.D.

SALT AND THE HEART by Edward T. Yorke, M.D. Drapkin Books, Linden, N. J., 1953. $3.45

This is an interesting little book written by a physician whose prime interest is cardiology. The first part of the book is written in narrative style and is devoted to the effect of salt on cardiovascular disease, particularly congestive heart failure. This portion of the book is very elementary but the author's approach to the subject is quite interesting. The story is about an old, retired sea captain, "Old Salt," who is unable to tolerate the unrestricted use of salt in his daily diet.

The second part of the book is devoted to the preparation of a low sodium diet which is, perhaps, the most important part of the book. The subject is presented in such a manner that even the layman can prepare a low sodium diet with reasonable accuracy. The book is recommended as supplementary reading for the general practitioner and the layman.

MICHAEL DIMAIO, M.D.

OGGI NON VISITO . . . PERCHÈ MI GIRA . . . LASCIO IL TERMOMETRO . . . PRENDO LA LIRA (Closed Today . . . I Just Don't Care . . . I Leave the Thermometer . . . and Take Up the Lyre) by Ugo Piazza. Edizioni Minerva Medica, Torino, 1955, Lire 1500

Dr. Piazza is a popular figure among the Italo-Americans of Providence, since his visit to the city two years ago and his weekly broadcasts from Rome on station WRIB. Dr. Piazza has a large family, a large dermatologic practice, right in the heart of the Eternal City, and is kept busy by the medical press. In addition to all these activities and to relax from the busy daily routine, he composes medical comical poetry of a most enjoyable kind. His verses are coming out with the speed of a high pressure pure water spring and are delightful.

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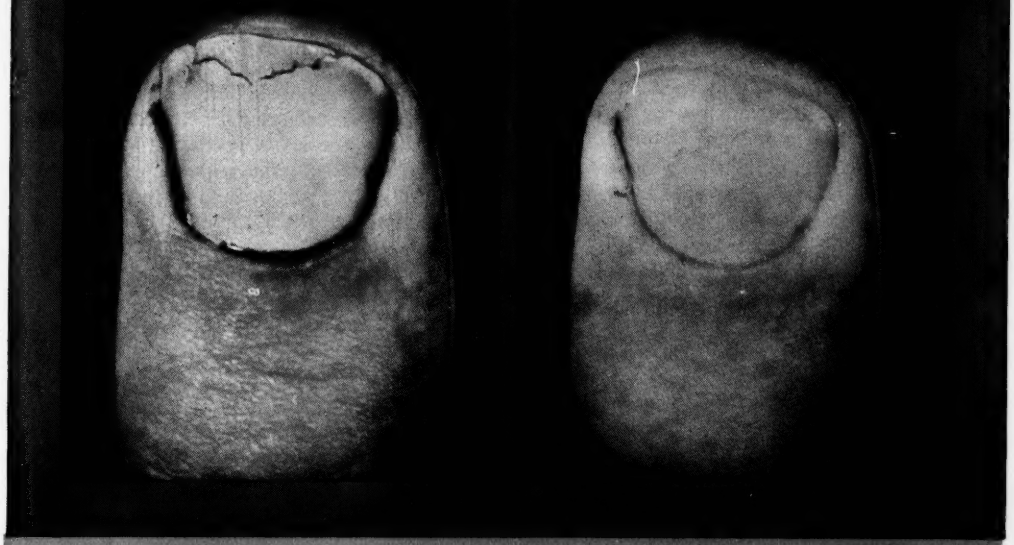
KNOX Protein Previews



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2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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BOOK REVIEWS

concluded from page 656

The poet-wit has a field day with our dermatologic puzzles, with the warring pediculus, the spirochetes, the inevitable enema, the vitamins craze, the detail man eloquence, etc., etc.

A serene, laughing Aesculapius, offering his peaceful mind as a reminder that there is always time for a good clean laugh.

The book is well illustrated by cartoonist Fratalocchi.

The cartoon on allergy, for example, shows an Italian forced to refuse a most alluring dish of spaghetti because of the clam sauce. Interesting are the verses devoted to medical history.

The book represents a valuable addition to our unique Davenport collection of books by physicians on non-medical subjects. I hope a Piazza-minded colleague, versed in both languages, will give us an English translation.

F. RONCHESE, M.D.

A TEXTBOOK OF PHYSIOLOGY. Edited by John F. Fulton with the Collaboration of Others. 17th ed. W. B. Saunders Company. Phil., 1955. $13.50

This new edition of physiology text presents many revisions and additions to older concepts so that even the recent medical graduate will find a wealth of material to absorb. Exactly fifty years have passed since the first edition by Doctor Howell and five years since the sixteenth edition. Among the contributors is Paul F. Fenton of our own Brown University Biology Department writing on the digestive system. Among the advances in fundamental physiology now included are completely rewritten chapters on the physiology of the nervous system (for which the book in the past was highly regarded), body fluids, kidney function, respiration and a new chapter on energy transformation in nerve cells and acetylcholine by Doctor David Nachmansohn, the eminent authority in this field. Recent important change in concept of the regulation of the autonomic nervous system by the visceral brain is recognized by a new chapter on the limbic system which brings to the fore the part played by the cerebrum in regulating visceral function and patterns of emotional expression. It was startling to read that the hypothalamus is no longer considered the chief area of autonomic function in the forebrain, but that in the oldest part of the cerebral cortex there is a designated limbic system to influence autonomic reactions. Although these studies are in their infancy, they are providing a rational basis for certain behavioral and EEG manifestations of psychomotor epilepsy.

To the reviewer the chapter on hemodynamics of the blood was a welcome revelation of some of the principles of the rapidly expanding field of rheology, the science of flow and elasticity, not easily found elsewhere.

The illustrations, tables and references are well up to date for a subject that expands as physiology does. One instance was noted where the figures of a table taken from another recent text on body water were revised again by that author to be the latest available data. The authors are to be commended on their revisions and exclusion of unessential material making the subject matter more digestible to the student and practitioner alike.

ABRAHAM SALTZMAN, M.D.

PRESENT-DAY PSYCHOLOGY edited by A. A. Roback. Philosophical Library, New York, 1955. $12.00

This new anthology brings up to date the experimental work in human behavior. The compilation covers the various areas of depth psychology from the point of view of recognized experts in each particular dissection of the human person.

The whole volume deserves attention because of its fine presentation and clear exposition of the present experimental situation and needs in the areas considered.

Thumbing through this book leaves one with a feeling of having had an adventure in the world of psychological ideas. No matter what one's personal idea about psychology might be, he recognizes the service this anthology renders to the profession in the depth, scholarship and magnitude of the work (995 pages).

For the student of psychology the full treatment of basic issues in experimental psychology is presented in one volume. For the busy clinician and doctor it is a sourcebook ready at hand.

The anthology should be a valuable addition to the library of psychological literature.

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RHODE ISLAND MEDICAL SOCIETY
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BEGINNINGS OF MEDICAL EDUCATION IN R. I.

concluded from page 651

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KEY—JHL: John Hay Library, Brown University;
RIHS: Rhode Island Historical Society Library;
PPL: Providence Public Library;
RIMS: Rhode Island Medical Society Library;
RIH: Rhode Island Hospital Library;
MS: Manuscript.

PROVIDENCE MEDICAL ASSOCIATION

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Medical School. Thomas A. Warthin, M.D., Chief of Medical Service, West Roxbury Veterans Hospital; Associate Clinical Professor of Medicine, Harvard Medical School.

The summary of the case was submitted to the membership in advance of the meeting.

As has been the case in the past two years, the first scientific meeting of the year was very successful. The discussion of the case was excellently handled by the visiting physicians, Dr. John C. Leonard and Dr. Thomas A. Warthin. Dr. Marshall N. Fulton did an excellent job as moderator of the conference.

The diagnosis of the case was an undifferentiated bronchogenic carcinoma of the lung with metastases to the liver, brain and adrenal glands. The patient also had acanthosis nigricans.

The meeting was adjourned at 10:00 P.M.

Collation was served.

Attendance: 105.

PHLEBITIS

concluded from page 631

bolism, a major operation such as a vena cava division should not be done. Sometimes a large clot may be present and give a few physical signs. In such cases I believe the electrocardiogram is of value in demonstrating right heart strain. If this is the case, anticoagulant therapy rather than vena cava division is the choice.

Many physicians believe that a vein division produces a higher percentage of the postphlebitic syndrome than other methods of treatment. This is very difficult to evaluate, and I know of no definitive study. From our own experience, I believe that the postphlebitic syndrome is more closely related to the severity of the initial phlebitis than to the type of therapy used.

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WHAT HAVE YOU TO SAY ABOUT HOSPITAL ACCREDITATION?

In June, 1955, the House of Delegates of the American Medical Association authorized the Speaker to appoint a committee " . . . to review the functions of the Joint Commission on Accreditation of Hospitals . . ." and ". . . to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on Accreditation of Hospitals."

This Committee was appointed, and now, in undertaking the task assigned to it, is seeking to obtain from physicians and others their observations concerning the functioning of the Joint Commission.

It is obviously impossible for the Committee to contact all physicians and others who may have observations or comments concerning the matter of hospital accreditation.

The Committee, therefore, is publishing this appeal, through the cooperation of the RHODE ISLAND MEDICAL JOURNAL, to obtain a cross section of observations concerning the accreditation program.

The Committee is interested especially in the following:

1. The general understanding by physicians of the functions of the Joint Commission.
2. Whether the method of appeal from an adverse ruling regarding accreditation is satisfactory.
3. The effect on the individual physician's hospital connections due to actions of the Joint Commission.
4. Whether any organizations not now represented should have official representation on the Joint Commission.
5. The effect of the Joint Commission's requirements concerning such matters as staff meetings.
6. The pros and cons of separating administrative and professional accreditation functions in the inspection of hospitals.
7. Constructive suggestions for improving the hospital accreditation program.

Any comments from individual members or state and county societies should be addressed to:

W. C. Stover, M.D., *Chairman*
Committee to Review Functions of Joint
Commission on Accreditation of Hospitals.
535 North Dearborn Street
Chicago 10, Illinois

These comments should reach the chairman not later than January 15, 1956.

W. C. Stover, M.D., *Chairman,* Boonville, Indiana
John F. Burton, M.D., Oklahoma City, Oklahoma
Gerald D. Dorman, M.D., New York, New York
George F. Gsell, M.D., Wichita, Kansas
Eugene F. Hoffman, M.D., Los Angeles, California
T. C. Terrell, M.D., Fort Worth, Texas
George Unfug, M.D., Pueblo, Colorado